

THE MEDICAL AND SURGICAL REPORTER.

Whole Series, }
No. 288.

PHILADELPHIA, APRIL 26, 1862.

{ New Series,
Vol. VIII. No. 4.

ORIGINAL DEPARTMENT. COMMUNICATIONS.

Researches and Observations on Pelvic Hæmatocele.

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Introduction.—At a meeting of the New York Academy of Medicine, held on the fifth of February last, I had the honor to read a paper on Pelvic Hæmatocele, which has recently been published by order of that body; but as my remarks on that occasion, though characterized by a distinguished member as an “excellent resumé of the subject,”* were accompanied by a somewhat lengthy report of the invasion, progress, treatment, and termination of a most interesting case of this singular affection, I felt myself compelled to dismiss with a passing notice some points of sufficient importance to warrant further consideration.

Moreover, since that time, I have enjoyed opportunities for additional investigation, by careful dissections of the organs and tissues involved, as well as by experiments—original so far as I know—which would seem to go far toward settling disputed questions touching differential diagnosis more especially.

My design on the present occasion is simply to supply to a certain extent such deficiencies, and to make known the nature of these experiments and the conclusions to which they tend; and as the “subject, with a few notable exceptions, might be said to be as yet undiscussed,”† my remarks, thus amended, may contribute in some degree toward filling up a hiatus in Ameri-

can medical literature, which, for the honor of our progressive science, should no longer exist. I propose, therefore, in addition to the original paper, with one or two unimportant alterations, to present a few facts and arguments confirmatory of opinions which I have heretofore entertained, and to some extent expressed.

History of Pelvic Hæmatocele.—Whether intra-pelvic hæmatocele was understood or even recognized as a distinct disease in the days of Hippocrates and Galen, or the Greek and Roman physicians during some centuries subsequently, matters but little in a practical point of view, and a discussion of the question would more properly belong to an extended treatise on this subject. There can be no doubt, however, but that this, as well as many other “diseases well known to the ancients, and fully described in their writings, have been lost from sight and observation for many ages; so that when detected again in our day, they appear in the light of entirely new discoveries.”*

Without stopping, therefore, to analyze the observations of Ruysch or his cotemporaries, it may suffice to remark that ABOUT THIRTY YEARS ago, Professor Recamier, on making an incision into the posterior vaginal wall, for the purpose of evacuating the contents of a supposed abscess, discovered that instead of pus a copious discharge of black, disorganized blood followed. Some years subsequently, M. Velpeau,† and perhaps one or two others, reported cases of a similar character; but up to 1850, our knowledge of the pathological lesions preceding and accompanying this peculiar kind of tumor was very limited.

The escape of blood into the recto-uterine cul-de-sac of the peritoneum is a fact that has been so long and often clearly demonstrated as to

* Clinical Lectures, by Professor Simpson.—Subject, “Pelvic Cellulitis.”

† Mémoire sur les Cavités closes.

* Dr. Watson's remarks on my paper. † Ibid.

leave no room for doubt; but I think it is safe to assert that, up to twelve years ago, the annals of medicine and surgery did not present more than half a dozen well-authenticated cases of encysted pelvic hæmatocele. Indeed, as regards British and American medical literature, we might have looked in vain for the slightest allusion to its existence; and even yet, some of our standard works on the diseases of females deny the subject a single chapter.

Dr. Tilt,* of London, (perhaps from the fact of his having been a pupil of Recamier,) was the first author in Great Britain to enlighten the profession by an interesting paper on this affection, read before the Medical Society of London in 1853.†

Dr. West soon afterward devoted the greater part of a lecture to its consideration; and Prof. Simpson has lately‡ favored his pupils and the profession with some valuable practical views on the subject. In this citation, it is gratifying to be able to state that so early as 1855 a case presented itself in the clinic of Prof. Bedford, of New York, who illustrated the correctness of his diagnosis by penetrating the tumor. This is a highly interesting case, and may be found pretty fully reported in that author's valuable Treatise on the Diseases of Women. Within the last few years cases have occasionally appeared in the medical journals of this country, but for the most part only the more prominent features in each have been referred to.

To French physicians, therefore, almost exclusively, and to Prof. Nélaton in particular, are we indebted for our present, though limited, knowledge of its pathology; for no sooner were the enthusiasm and energies of that illustrious surgeon enlisted in this new field of inquiry, than the medical literature of the country abounded with discussions, essays, and cases; each contributor discovering symptoms and lesions in support of a particular theory.

Some contended that the extravasation took place *into* the peritoneal cavity almost exclusively, and there by its presence quickly excited inflammation in the serous membrane, by which process it soon became encysted; while others, whose opinions are equally entitled to consideration, acknowledge two forms of hæmatocele, viz.,

the *intra*-peritoneal, as when the hemorrhage comes from the Fallopian tube or serous covering of the ovary itself, and the *sub*-peritoneal, denoting that the extravasation was into the cellular tissue, and generally from veins within the folds of the broad ligament.

To review at length all the various theories and opinions put forth since the publication of M. Viguès' thesis in 1850* to the present time, would be a task as fruitless as it would be foreign to the purport of this paper, which is merely to offer some practical remarks touching the causes, nature, and treatment of this singular affection, suggested, mainly, by practical observation of cases occurring in my practice, one of them, in particular, being of a somewhat remarkable and highly interesting character.

But one monograph of any pretensions that I am aware of, in any language, has yet appeared; and as this able treatise is from the pen of Dr. Voisin, a worthy pupil of M. Nélaton, statements from such a source are of the utmost importance. I will, therefore, take the liberty of making some of the opinions of this author, and those of other observers therein alluded to, the subject of a few passing remarks.

A learned reviewer,† speaking of M. Voisin's work, very properly says, "it must be looked upon as a monograph simply on the *intra*-peritoneal form of pelvic hæmatocele, and on this variety of the affection much interesting information is afforded."

In acknowledging but this one form of hæmatocele, that author goes so far as to say that a bloody tumor in any other situation outside the recto-uterine cul-de-sac is not the result of menstrual disorder, does not necessarily occur at a catamenial period, but must be the consequence of some injury, and should, therefore, be designated as *thrombus*. This is truly "a distinction without a difference," except in so far as the fate of the patient is concerned, and entirely opposed to the opinions of Richet, Scanzoni, Nonat, Prost, and other high authorities, worthy of more consideration than seems to have been accorded by Voisin. Moreover, a careful perusal of the cases collected by this author must convince any impartial reader that many of them offer examples of that very form of hæmatocele which he seems to ignore.

* Dr. Tilt, in his most excellent "Treatise on the Diseases of Women, and Ovarian Inflammation," devotes a separate chapter to this disease.

† London Lancet, vol. i., 1853, page 164.

‡ Medical Times and Gazette, Aug., 1859.

* "Sur les Tumeurs Sanguines de l'Excavation Pelvienne chez la Femme."

† British and Foreign Med.-Ch. Rev., July, 1860, page 81.

An argument is adduced in favor of the intra-peritoneal theory, which I suspect many will fail to consider either conclusive or satisfactory, and were it not that he seems to rely on it as a strong negative proof of the correctness of his deductions, I should not allude to it here.

He says, in commenting upon M. Prost's description of a particular case* where the post-mortem appearances demonstrated that the extravasation of blood was sub-peritoneal, and "filled up the cellular tissue behind the uterus," that "anatomists deny the existence of cellular tissue in this locality." Not only does this style of reasoning appear far from conclusive, but I apprehend few would be impressed with the correctness of a theory requiring such questionable support; because, whether that which M. Prost called cellular tissue, was really such, or some of the products of peri-uterine inflammation, or, indeed, whether we admit or deny the presence of such tissue in this particular location, there is one fact which we have no right to question, and that is, that the contents of the cysts were external to the peritoneum.

The intra-peritoneal theory would seem to be strongly sustained by post-mortem appearances in most of the cases noticed; but this is no more than might be looked for when we reflect how much more alarming and fatal this particular form of the malady must be. It is obvious, therefore, that the pathological changes observed in cases of death resulting from this cause lose their value in a statistical point of view; were it otherwise, I fear neither surgical interference nor the "*vis medicatrix nature*," so much relied upon by Prof. Nélaton and others, could account for the happy terminations noticed in many of the cases recorded by Voisin himself.

Definition.—The tumor to which the term *hæmatocele*, or *hæmatoma*, has been correctly applied may be defined *an extravasation of blood into or beneath the pelvic peritoneum*; and on account of the space in which this form of tumor has been, for the most part, noticed, it has generally been described as "*recto-uterine*," "*retro-uterine*," or "*peri-uterine*." But, as the extravasated fluid does not invariably select either of the locations thus indicated, the more correct, and at the same time comprehensive term, of *pelvic hæmatocele* should, I think, be used, as it in-

cludes every form of this affection, whether intra- or sub-peritoneal, diffused or encysted. The following case, which has come under my own observation, may more clearly elucidate what I mean.

Case I.—A lady, aged twenty-one, of robust habit and good constitution, was married at the age of sixteen, and has given birth to three children. In her first labor she had convulsions, and was delivered of a well-formed, but dead child, by forceps. She soon recovered, however, without any unfavorable symptom other than might be anticipated in such a case; her second confinement was natural in every respect, but on the third day she was taken with chills and symptoms of metro-peritonitis, from which she also quickly recovered, and enjoyed excellent health up to her third labor. Her convalescence on this occasion was uninterrupted, except that she complained of a continual soreness in the right ovarian region, first noticed when she commenced to sit up. At the expiration of three weeks—this pain still continuing—she ventured out, but had not gone far before she was seized with most acute suffering or "*cramp*," as she termed it, in the lower portion of her abdomen, accompanied with tenesmus and difficult micturition.

These symptoms gradually subsided under proper antiphlogistic treatment, but the original pain remained as before, and continued, with occasional remissions, for the following nine months, when, during an unusually severe paroxysm, she felt as if something had given way, and soon after discovered a *firm* tumor occupying the right ovarian region; the swelling was about the size of a turkey's egg, and tender to the touch. She was not nursing, and menstruation was perfectly regular. After three or four months the tumor became less sensitive and smaller, and in less than twelve months there was no trace of it to be found, and her health improved rapidly. The principal treatment consisted in counter-irritation, and the internal and topical use of iodine.

The period of life at which *hæmatocele* most frequently occurs, is between twenty-five and thirty-five years, "when the sexual system is in its greatest vigor," and the pelvic organs are consequently more prone to congestions. For similar reasons, persons of a sanguineous temperament, or given to plethora, are most frequently the subjects of it.* It has also been generally noticed

* The following are M. Prost's own words as quoted by Voisin, page 214: "*Elle a son siège dans le tissu cellulaire existant à la face postérieure de l'utérus.*"

* Voisin.

that the period of invasion is immediately before, during, or soon after the catamenial flow. This latter fact, however, seems to have led many observers thus far into a very erroneous and illogical conclusion, when they attribute the malady to *disordered menstruation*, as it would appear, almost exclusively. Thus Trousseau considers it the sole cause, and says: "It is the result of a hemorrhagic diathesis characterized by an exaggerated catamenial flow;" but this looks very like a confusion of causes and effects, for, if the quotation mean anything, it merely asserts what no one can deny, that a hemorrhagic diathesis may be a predisposing cause of menorrhagia.

Would it not be more in accordance with the present advanced state of ovarian pathology, based as it is upon the physiology of the generative organs, to seek for the cause in some pre-existing lesion? It is true, during menstruation the vessels of the uterus, ovaries, and Fallopian tubes are enormously congested, and that hemorrhage to a limited extent, from one or more of the vesicles of De Graaf, is a perfectly normal phenomenon; and moreover, it is also more than probable that an excessive discharge of blood following the rupture of a vesicle is a frequent cause of the hypogastric pains of dysmenorrhœa, as well as the peritonitis which sometimes supervenes.

No less certain is it that regurgitation of menstrual fluid from tubular or uterine occlusion has often been the sole cause of these hæmatocèles; but is it at all likely that hemorrhage to such an extent as to produce even a moderately-sized retro-uterine tumor can take place from a healthy ovary, or the vessels of a tube whose lining membrane is free from structural lesions? In other words, are not disorders of menstruation in very many cases wholly a result of that abnormal condition of the uterine appendages which might also predispose to this kind of hemorrhage?*

I am aware that Drs. West and Churchill, by some process of reasoning which does not seem quite clear, attribute most of the suffering referred to the ovarian region to "neuralgia," and an affection known by the somewhat vague and obsolete term of "ovarian irritation." I have also noticed, with no little astonishment, the extraordinary assertion of Dr. Jas. H. Bennett, at page

193 of his work,* that "in nineteen cases out of twenty in which the ovarian regions are the seat of deep, dull, aching pain, and appear tender and rather swollen, there is no actual ovarian disease whatever."

Nevertheless, the researches of Professor Simpson, Drs. Rigby, Ashwell, Robert Lee, Tilt, and other authors have led them to conclusions directly at variance with those of the writers just quoted; and I have no hesitation in declaring as my conviction, that in eighty per cent. of the examples of retro-uterine hæmatocèle recorded, where the condition of the patient and her symptoms anterior to the accident have been carefully noticed, there were unmistakable evidences of ovaritis,† which in time may have produced a varicose condition of the vessels, and, perhaps, softening of the tissues, thereby modifying the nervous stimulus by which these organs promote and control the menstrual secretion, and ultimately ending in rupture and extravasation.

On this subject Dr. Ashwell says:—

"Of all the organs of the human body, scarcely any seem so prone either to functional or organic disease as the ovaries; for I can with truth say that I have rarely, when examining these important organs after death, found them entirely healthy."

And Dr. Robert Lee declares that—

"In many cases of disordered menstruation, chlorosis, and hysteria which we have observed, the symptoms have been clearly referable to certain morbid states of the uterine appendages, and decided benefit has resulted from the application of those local remedies which were employed with a view of subduing the irritation, the congestion, or the inflammation which appeared to be present in those parts of the uterine system."

To be continued.

The Tape-Worm, and Kousso as an Anthelmintic.

By A. G. WILKINSON, M.D.,

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The views of the writers of an early date, both with regard to the origin of intestinal worms and their uses, are amusing as well as interesting.

An old writer asserts that the intestinal worms "by their motions cause a gentle irritation in aid

* M. Devaltz is of opinion (and very correctly, I think) that a varicose condition of the veins of the broad ligament is by far the most frequent predisposing cause of hæmatocèle, because these vessels in this situation are not provided with valves.

* Fifth American, from third London edition.

† Varicosity of the vessels may be either a cause or a consequence of ovaritis. I would, therefore, suggest that *ovarian phlebitis* might more correctly be applied to designate the actual condition of the parts.

of the intestinal functions, which, moreover, may stimulate the other viscera to the discharge of their duties and prevent their falling into a state of inactivity favorable to the commencement and increase of organic diseases." Another writer says: "They drink up the superabundant chyme, chyle, or mucus in the bowels." Again we read in a *Bridgewater Treatise* that "they were created as a wholesome check on the pride and vanity of man, as trials of his patience and other virtues; and, finally, to secure to him an entrance into an immutable and eternal state of felicity, when that of probation is at an end, so that the gates of death may be to him the gates of peace and rest."

For a long time naturalists were entirely in the dark as regards the origin and growth of the *tænia*. Some contended for years that the worm was but the vivified mucus of the intestinal canal; others, that it was the same worm that was found in water and in certain vegetables. Some persons testified to having seen the *tænia solium* swimming in pools of water.

With regard to its growth, it was asserted that it must increase in one of these three ways, viz., either at the head, at the sides of the joints, or at the tail. Bremser relates an experiment that at first seemed to prove that the worm added joints to the tail:—

A gentleman troubled with the parasite, often found it protruding from the anus. The worm upon slight pressure would draw itself again into the rectum. The gentleman was requested, the next time the *tænia* presented itself, to sew a colored thread through it, counting the number of joints between the thread and extremity of animal. The gentleman followed the directions, marking the worm *three inches* from the end, and counting *five joints* on the portion thus marked off. The worm was expelled one month afterward, and the part below the thread consisted of *forty joints*, measuring one foot in length. This experiment was, for a time, considered as proving satisfactorily that the worm increased by the addition of joints to its lower extremity. A school-boy, however, upon making the rule-of-three statement, would see that if five joints measured three inches, forty joints would measure two feet and not one. In this case, probably the worm upon being pierced with the needle contracted itself so closely together that the forty joints were but three inches in length.

After such contraction it would be almost im-

possible to determine accurately the exact number of joints. The writer of this article once enjoyed an opportunity of testing this very thing. A *tænia solium* was brought to him a few moments after its expulsion, while it was in active motion throughout its entire length. The head was taken by pincers, and with about a yard of the worm placed over the side of the vessel upon a piece of newspaper. The *tænia* then drew its entire length (over eighteen feet) over the side of the vessel upon the paper. A few slight pressures with a sharp-pointed stick, without piercing at all, caused the worm to contract so closely as to greatly increase its breadth and thickness, and diminish its length to about one-third. It was then hardly possible, with the naked eye, to distinguish the joints. The experiment of Bremser related above seems then to prove nothing at all. Another theory was, that from next to the last joint a small projection arose, which grew until it exactly replaced the last joint and expelled it from the mass. In no specimen, however, has any such joint been found partially developed.

Linné for a long time held the opinion that each joint was a separate and perfect individual, and that these individuals fastened themselves mechanically together, forming one continuous canal, through which nourishment came from the mouth of the first animal. Again, the marginal foramina were thought to be the mouths through which each joint received its nourishment. Afterward, they were considered to be merely useful in enabling the parasite to retard its position upon the walls of the intestines. Thus much for old exploded notions.

It is now universally admitted that the *tænia* is one distinct animal of an indefinite number of joints, and that its growth is from the head and neck. The portion destitute of joints, immediately adjoining the head, increases in length and develops a joint. The parts usually passed off with the feces are the fecundated or impregnated joints. The marginal foramina are irregularly alternate, and sometimes as many as six are found upon one joint of the worm. Each foramen contains a complete genital apparatus of both sexes, as the animal is a hermaphrodite. Immediately adjoining the little depression and orifice which communicates with the ovary, is the male organ, which communicates directly with the receptacle of the semen.

The joint, or *proglottis* as it is improperly called, (and why so named a scholar would be

puzzled to tell,) when mature and filled with eggs, becomes congested, separates itself voluntarily from the rest of the worm, and passes off in the feces. Each egg consists of a body armed with three pairs of hooklets, by which it is able to burrow. The egg is closely enveloped in a hard substance, which will protect it and preserve its vitality for an indefinite period. By some it is contended that these minute eggs are taken up with the sap into the body of certain vegetables that are eaten in great quantities by swine. At any rate, these eggs find their way into the bodies of swine, and the flesh when filled with them is called *measly pork*. After being introduced into the body of the animal, the parasite penetrates the tissues and is developed into a *CYSTICERCUS CELLULOSÆ*. In its developed state it is found "in the ordinary muscles in the cellular intervals between the fibres, and also on the surface of the muscles immediately beneath their fascial investment." After the egg has found its proper nidus it is encysted, its hooklets drop off, and a growth inward commences which becomes the body of the *scolex*, and is, when perfected, an oval cyst about half an inch in length, with a white globular body in the centre. As the *cysticercus cellulose* forms in man the *tænia*, it is called the *scolex* of the *tænia*. Upon pressing the adult *scolex*, the globular portion will be made to protrude, and it then "admits an anatomical division into two parts, viz., ventral portion, and neck." The *cysticercus* has no reproductive organs, but when the flesh containing it is eaten by man, and it finds its proper nidus, it loses its caudal vesicle, becomes articulated, and assumes the form of the *tænia solium* or jointed tape-worm.

If, however, the eggs of this *tænia* itself are given to a man in food, they do not develop, but are digested and pass off. Some naturalists assert to the contrary, but have not clearly proved their assertion. When the *cysticercus* is given to a person in food, in a short time tape-worms of a few joints are expelled by the usual anthelmintics. Again, if the *cysticerci* taken from measly pork are given to swine in food, they do not develop at all, while the eggs of *tænia* given in swill, form in a short time the *cysticerci*. It is by no means probable that every time measly pork is eaten tape-worms are produced, but it would seem that a sluggish state of the bowels would favor their production, as greater facilities are given to the *cysticercus* to

hook itself firmly upon the sides of the intestines.

The accompanying drawings were taken mainly from a series of plates published some years since at Milan, and now in the possession of the Smithsonian Institution.

Fig. 1.

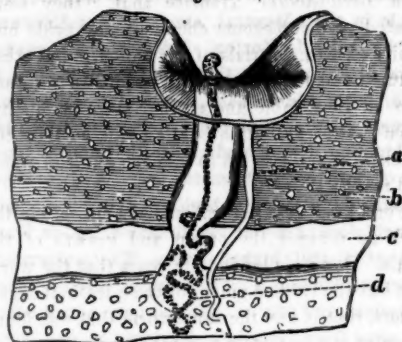


Fig. 2.



Fig 3



Fig. 1 represents a portion of a joint of the *tænia solium* magnified 250 times. a. The oviduct. b. Tegumentary follicles. c. Alimentary canal, not communicating with the penis. d. The tortuous seminal canal.

Fig. 2 gives a more distinct view of the external genital organs.

Fig. 3 represents a *cysticercus cellulose*.

Upon each joint of the *tænia solium* may be seen two faint parallel lines—one near each side. Some still dispute that these form the two continuous canals through which nourishment is conveyed from the mouth through the entire worm, and are seeking for some complicated digestive apparatus in each joint. Would not, however, a complicated digestive apparatus seem entirely superfluous, as the animal lives upon chyle, which is of course entirely prepared for the purpose of nourishment? As if, forsooth, that miserable worm could improve upon an operation just performed by man—the most perfect animal in existence! In the worm which I carefully examined while it was still living, I found that upon pressing these faint lines with the thumb nail, a white substance, bearing an

exact resemblance to chyle, was forced from the ends of the joint.

At my side lies a list in German of some fifty distinct methods of treatment, each of which has been often successful. But of the various methods of expelling the parasite, I will speak of only one.

Some time since my attention was called to an article in the "MEDICAL AND SURGICAL REPORTER," by Dr. H. L. Horton. I determined to make a trial of *kousso*. In this country *kousso* has, I think, been seldom used, for two reasons, viz., extreme costliness of the article, with difficulty of obtaining it pure, and a somewhat ungrounded fear of bad results from its use. At one time *kousso* sold in Paris as high as twenty francs for a single dose of about two drachms, and in England at a still higher price. The pulverized flower of *kousso* is now brought directly from Abyssinia, and can be obtained pure at a moderate price from first-class druggists in our large cities. It is, of course, better to get the flowers entire, as foreign substances are so often incorporated in the powder.

In Abyssinia the dose is six drachms in cold water. As, however, *kousso* is largely composed of tannic acid, which is best dissolved by hot water, it would seem preferable to administer the remedy in this form. *Kousso* is a drastic cathartic, and the natives of Abyssinia, by a constant and repeated dosing with it, frequently produce prolapsus ani. The patient to whom I administered it, although afflicted with the piles, suffered no inconvenience at all.

In the early part of last summer a gentleman applied to me, saying, "Although you are not a physician, perhaps, from your study in the Paris hospitals, you may have gained some information that will enable you to treat me successfully." The gentleman complained of long-continued and depressing debility, for which no cause seemed to exist. The case had been variously diagnosed, and treated with quite unsatisfactory results. The gentleman, however, had received great benefit from foreign travel, and entire rest from literary pursuits. The general symptoms seemed to indicate a chronic disease of the liver, and the patient had often been treated for that difficulty. Few of the symptoms of *tænia* were present in this case. For some years the tongue had been covered with a thin, white coating, and the patient had, for years, suffered from an intolerable itching of the nose. In fact for months at a time

the interior end of the nostril had been covered with a small sore. Strange as it may seem, *tænia* are very rarely present in man without producing this itching of the nose. In place of the usual dullness there was an unusual brightness, in fact almost a flashing of the eye. Although the case hardly seemed a clear one, I concluded to treat the gentleman for *tænia*. For particulars I refer to my diary.

July 30th. Patient somewhat emaciated, but with good appetite and regular pulse. Ordered entire abstinence from food, and the following:

℞. *Ol. ricini*, fʒi.

July 31st. Patient a little weak; bowels had operated quite freely. Ordered continued abstinence from food, and the prescription of the preceding day.

August 1st. Pulse indicated considerable weakness. At ten o'clock A.M. ordered the following:

℞.—*Ol. terebinth.* fʒss.

To be followed, at one P.M., by *ol. ricini*, fʒiss.

During the afternoon and evening there came away, in short portions, some six feet of a *tænia solium*, and finally a *tænia lata* (or properly, *bothriocephalus latus*) about ten feet in length, upper part entire, but wanting the lower joints.

August 2d. Allowed the patient some light food, and ordered the following to be taken at five P.M.:—

℞.—*Ol. terebinth.* fʒiij;
Ol. ricini, fʒi.

Bowels moved freely, but no further traces of *tænia* or of the broad tape-worm. It has been very often asserted by writers that a *bothriocephalus latus* has never been found in an Englishman or American who has never been in Switzerland or Russia. I felt now prepared to refute that; but, upon inquiry, found that the gentleman had been in Switzerland just a year before the expulsion of the worm. Query—Does a worm, then, grow ten feet per year?

Between this time (August) and January, 1862, the gentleman gained some twenty pounds of flesh, and enjoyed the most perfect health. January 10th he called upon me, saying that, notwithstanding his perfect health, he was still troubled with the parasite, at the same time showing joints of the *tænia solium* that he had lately found in the feces. I ordered entire abstinence from food for one day, and a heavy dose of castor oil; and as my attention had been mean-

while called to kousso, the following for the next day at six P.M.:—

B.—Pulv. kousso flo. 3ijss;
Aque bullientis, Oss.

M. et ft. infus. S. To be drank in small portions during a half hour.

At eight o'clock A.M. ordered again ol. ricini, f3i. At half-past eleven o'clock that same evening there came away a tænia solium measuring over eighteen feet in length.

The patient experienced no different effects from the kousso than from a bowl of warm tea.

From a careful examination of the various cases recorded in an extensive medical library, I am induced to believe that in the majority of cases unsuccessfully treated with kousso, the kousso has been either impure or not given in sufficiently large doses.

Any one wishing to try kousso, with absolute certainty of having the pure article, can obtain from Koert du Bois, Mott Haven, New York, some of the same used by both Dr. Horton in his published case, to which I referred, and myself in the present instance.

In case any reader of this article may be visiting the U. S. Patent Office, I would recommend to him a little quiet amusement. Let him obtain from the attendant, from the upper shelf of case No. 49, containing surgical instruments, the model of the patent of Alpheus Myers, of Logansport, Indiana, granted November 14th, 1854. He will find the specification to be Nos. 11,942 and 11,943. The TAPE-WORM TRAP is a very small hollow tube of gold so arranged as to contain a small piece of cheese for a bait. The patient, after a fast of four or five days, is ordered to swallow the trap, with a string attached.

It is claimed by the inventor that after a long-continued fast, the worm comes up into the stomach, and will then greedily seize the cheese, be caught in the trap, and can be easily pulled out. I quote from the inventor:—

"The cord is fastened to some conspicuous place about the patient, who is left to his ease from six to twelve hours, and during this time the worm will have seized the bait and have been caught by the head or neck. The capture of the worm will either be felt by the patient or ascertained by the motion which will be visible in the cord. The patient should rest for a few hours after the capture, and then by a gentle pulling at the cord the trap and worm will, with ease and perfect safety, be withdrawn."

Imagine to yourself the satisfaction with which a man could thus sit down and fish in his own

room, without even the accompanying tub of water; the patience and complacency with which, after waiting from six to twelve hours for a bite, he would then play his prisoner some hours more before landing him! Does not Mr. Alpheus Myers have good reason to believe that the shade of Izaak Walton looks down upon him in anger for this innovation upon the piscatorial art?

[A more extended account of this tape-worm trap was published in the REPORTER (while issued in the monthly form) for September, 1856, vol. ix. p. 431.—EDS. MED. AND SURG. REP.]

Medical Societies.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Reported by William B. Atkinson, M.D., Recording Secretary.

November 13th, 1861.

Concluded from page 65.

DR. BURNS had seen much of this very troublesome disease. He had been struck by the remarks of Dr. Darrach, as that had been his treatment for years. He believed, also, that the liver was the cause of the affection. By manipulation, he generally found tenderness at the base of the liver in nearly every case. Usually a little mercury, as hydrarg. cum creta, or calomel, with rhubarb or aloes, had a highly beneficial effect. He specially liked the moist fomentations to the abdomen, enveloping the liver from the spinal column to the epigastrium. As the blood is generally much deteriorated in protracted cases, he employed tonics, as quinine and iron, to rescue the little patient from the extreme exhaustion. Beef-tea, etc., with mild, bland drinks, are of great value. He did not doubt that bad nutrition, etc. had much to do with the production of the disease in his locality, (Frankford.)

DR. TURNBULL considered the name infantile remittent fever as a misnomer as applied to the disease so graphically described by the gentleman who opened the debate. It is now well understood that the disease, in almost every instance when met with, is the result of irritation or inflammation of the digestive mucous membrane, and would be better understood by the young physician as gastric or gastro-enteric fever; while the name remittent should be alone reserved for the well-known fever of that name, the result of malaria, characterized by distinct yet not entire remissions of all the symptoms about every twenty-four hours. To be treated in the summer by local and general depletion and calomel, and in the fall by quinine and arsenic.

DR. CONDIE considered the subject to which the attention of the members present had been

called by the able summary of the lecturer of the evening, one of the highest interest, inasmuch as the so-called remittent fever of childhood was one of the diseases which every practitioner would the most frequently be called upon to treat.

Under the somewhat vague and confessedly inappropriate name just referred to, there had been included, by different writers, without doubt, several distinct, and, in some respects, dissimilar diseases—the only features these diseases possess in common being more or less derangement of stomach and bowels, and fever marked by evening exacerbations and very decided morning exacerbations; the latter, often indeed, particularly in the beginning of the attack, amounting to complete intermissions.

When preparing the first edition of his work on the Diseases of Children, he had been on the point of omitting entirely any account of infantile remittent fever as a special disease, believing that, in treating of the several inflammatory affections of the alimentary canal in early life, he had said all that was necessary in relation to the morbid phenomena to which the term infantile remittent fever had been usually applied.

A temporary fever of a well-marked remittent character is, in young children, often the result of simple irritation of the stomach and bowels, induced by too much or improper food. It is particularly prevalent about Christmas times and other festival seasons, when children are tempted to indulge to excess in eating, and often of the most indigestible articles. Fried potatoes, a common dish served upon our tables, and partaken of largely by both adults and children, was, in the estimation of Dr. Condie, to be considered a prolific source of disturbance and disease of stomach in persons of all ages, but especially in young children.

The form of disease just referred to was seldom, Dr. Condie remarked, of any serious importance, excepting, it may be, in children endowed with very excitable constitutions, or who are predisposed to convulsive attacks. In the majority of cases it will get promptly well under a proper regulation of diet. In most cases, however, its removal will be facilitated by the administration of a smart but mild purgative, such as castor oil, or calined magnesia and rhubarb.

Young children are most unquestionably liable to fever of a remittent type, produced, as in the adult, by exposure to malaria. It is, consequently, most frequently met with in those localities and seasons where and when malarious diseases ordinarily prevail. A respectable physician, in a paper published a short time since in one of the New York journals, contends that the malarial fever just alluded to is the only one which, as it occurs in young children, can be properly recognized as remittent fever. He would remark, however, that the question is not, what should be viewed as the true remittent fever of early life, but to what maladies of infancy and childhood has the name been actually applied.

A common form of disease in young children

that has been included in the general denomination intermittent fever, is ileitis—a subacute inflammation of the lower portion of the small intestines, extending, in many cases, also to the upper portion of the colon. The acute dysentery of infants and young children is also not unfrequently described as infantile remittent fever.

There is still another form of febrile disease occurring in young children, which, up to a very late period, has been included under the general appellation of infantile remittent fever. Recently, however, its true character has been correctly made out—it having been shown to be in all respects identical with the typhoid or enteric fever of adults. The phenomena and general course of the disease just alluded to, according to Dr. Condie, are precisely the same as those of true typhoid fever, allowance only being made for some slight modifications, evidently imparted simply by difference of age. The presence of rose-colored spots and sudamina Dr. Condie has noticed in many cases. The morbid conditions detected after death in the lower portion of the small intestines, in the children who have labored under the disease in question, are precisely those which are now universally recognized as diagnostic of typhoid fever in older persons—allowance being made here also for some difference between the anatomical structure of the intestinal mucous membrane and its appendages in the infant and adult.

By nearly all the earlier writers on the diseases of children, the symptoms which are described by subsequent authorities as those of infantile remittent fever were referred to the presence of worms in the intestines. The *febris verminosa* of those writers was in fact nothing more nor less than the same disease, which is now known as the remittent fever of children. The falsity of the views entertained in this respect by the older writers has been very fully exposed; so much so, that vermifuge medicines are rarely prescribed by the physicians of the present day. There can be very little doubt that many of the severe and even fatal cases of "worm fever" alluded to by the older writers were actually produced by the very remedies administered to get rid of the supposed *causa morbis*—the intestinal worms. But, although the belief in the existence of a "worm fever" has been abandoned by all well-informed members of the medical profession, it is still cherished by the community outside of the profession; and we find that worm medicines are among the most popular and frequently administered domestic remedies. From their use, especially in the cases of young children, the utmost mischief has been known to result. Some of them are most active and irritating purgatives, while others of them possess acrid and even poisonous properties. Dr. Condie has actually seen an attack of the so-called infantile remittent fever brought on by the use of worm-destroying remedies.

Nearly all of the more protracted and least manageable forms of what is known as the remittent fever of children, Dr. Condie was convinced would be found, upon careful examination,

to be cases of simple subacute ileitis, or of the dothin-enteric form of ileitis observed in typhoid or enteric fever.

In respect to the therapeutics of infantile remittent fever, each of the forms of disease included in this general appellation, and to which he had referred in the course of his remarks, will require, he observed, to a certain extent, its own especial treatment. In neither of them, however, will very active treatment, in general, be demanded. The purgative system recommended by some writers on the disease is particularly inappropriate. It may, it is true, be necessary, in most cases, at the onset of the attack, to clear out the bowels by some mild purgative; but after this is once effected, the bowels should not be interfered with, but allowed to remain perfectly quiescent. The administration of aloes as a purgative, referred to by Dr. Darrach, he would certainly most pointedly condemn in any of the forms of disease included under the head of infantile remittent fever, or in any of their stages. From its employment he should certainly anticipate far more injury than good. Dr. Condie believed that one of the very best, mildest, and most suitable purgatives in the general run of cases would be calomel. It may be given in combination with an equal quantity of calcined magnesia, or by itself, and followed, after a short interval, by a dose of castor oil. In the commencement of very many cases of infantile remittent fever Dr. Condie has seen the best effects result from the administration of equal quantities of calomel and calcined magnesia, with the addition of nitre and extract of hyoscyamus. The quantity of each of the ingredients in this prescription is to be graduated by the age of the patient and the character of the attack.

It is very certain that no general and invariable plan of treatment can be laid down as applicable to all the cases of infantile remittent fever that are met with in practice. The remedies to be employed must, in a very great degree, be determined by the character and circumstances of each individual case. The judicious practitioner will carefully watch the disease, and adapt his treatment to the particular indications that may occur.

Rubefacients, followed by, or, in protracted cases, alternated with fomentations of a warm emollient character to the abdomen, Dr. Condie has found to be always productive of the most salutary effects. A flannel, wetted with spirits of turpentine, and kept on for a few moments at a time, constitutes, in the disease we are discussing, one of our best rubefacients. It may be followed by the application of cloths wrung out of some simple emollient fluid, or a soft mush poultice inclosed in a thin muslin bag. The daily use of the warm bath, when it can be done without too much fatigue to the patient, will, in most cases, be found advantageous.

In the early stage of very acute cases, leeches to the abdomen will occasionally be proper. When opportunely applied, they are, under the

circumstances referred to, productive of much good.

Dr. Condie was not favorable to the application of blisters, for the production of vesication, in any of the diseases of young children. As mere rubefacients, however, their use will be followed by the very best results in the more chronic forms of infantile remittent fever. They should be left on only long enough to redden the skin, and followed immediately by a soft bread and milk poultice, with the addition of plenty of lard.

Protracted cases are often attended with frequent discharges from the bowels of a small quantity of dark colored and highly offensive fluid, having not the slightest trace of feculent matter. It is often the case that everything taken into the stomach as food passes quickly through the intestines, having undergone little or no change. In these cases the patient wastes rapidly away; he has a fastidious and variable appetite, a dry, parched, and discolored skin, with hectic fever during the day, and profuse sweats at night. Under such circumstances, Dr. Condie has found small doses of spirits of turpentine, given by the mouth, always beneficial, and often productive of the most surprising results. Soon after the turpentine is commenced with, he has known the appetite of the child to improve, the hectic fever to abate, the skin to assume a more natural feel, the night-sweats to disappear, the action of the bowels to become more regular, and the discharges of a more healthy appearance.

Dr. Condie usually administers the turpentine diffused in some aromatic water, and properly sweetened. A drachm of spirits of turpentine may be diffused in three ounces of fluid, by combining it intimately with seven grains of calcined magnesia. To the turpentine emulsion, he had often been in the habit of adding, and he thought advantageously, the tinctures of valerian and hyoscyamus. The dose of the turpentine, and of the hyoscyamus and valerian, must be graduated in each case by the age and condition of the patient.

Tonics and even stimulants are occasionally indicated in cases of infantile remittent fever. One of the best tonics, according to Dr. Condie's experience, was a solution, in water or alcohol, of the muriated tartrate of iron; it may be given by itself, or, when the prostration of the patient is considerable, in conjunction with the sulphate of quinia.

DR. WITTIG remarked that the disease under consideration varied in its character in different cases, from the difference in the cause by which it is produced. It may depend not only upon some primary lesion of the mucous membrane of the intestinal canal, resulting from cold, bad food, improper medicaments; but also upon certain secondary lesions, the results of previous affections of other organs and tissues. It is, moreover, intimately connected with whooping-cough; presents itself in the first stage of many eruptions, whether febrile or even altogether unconnected with fever in their course. It may

arise from, as well as give rise to, inflammation of the membranes of the brain; and is generally associated with the typhoid disease. It is based upon a more or less congested state of the intestinal mucous membrane, which, upon post-mortem examination, will even show the indications of preceding inflammation, such as suppuration, ulceration, and perforation.

The type of any fever is either remittent or continued. There is no intermittent fever; what is generally so called, is an affection of the nervous system connected with fever, which will cease with the termination of the paroxysm. Dr. W. does not like the name given to the disease under consideration, which bears a close analogy to the catarrhal affection of the mucous membrane of the respiratory organs.

Of the various characters of the remittent fever, the synochal and the torpid are of greatest importance in a therapeutical as well as pathological point of view. In cases exhibiting the former character there is some approximation to the phlogistic process, and the affection of the intestinal mucous membrane may be complicated with congestion, or inflammation of the meninges of the brain; here the brain should be first relieved by an active antiphlogistic treatment, but not without a proper regard being had to the irritated condition of the bowels. The torpid cases, on the contrary, demand such remedies as promote the various secretions by stimulation.

The diagnosis of remittent fever from the typhoid disease, rests upon the peculiar stools occurring in the latter, and the swelling of both the spleen and liver; but it is sometimes the case, that the tumefaction of the whole abdomen, which is present, will not allow us to detect these latter lesions. Dr. W. has had recently such a case under his care. The parents of the patient, a boy about five years old, suffering at the same time from hooping-cough, attributed his ailments to worms; but the roseola typhosa, the peculiar diarrhoea, etc., which afterward set in, proved the case to be one of the typhoid disease.

The ulcers discovered upon a post-mortem examination may be mistaken for those which occur in the typhoid disease, and accused of being the immediate cause of death. They are distinguishable, however, by their margins not being elevated, and their middle depressed, and by their widest diameter not being along the intestines, as is the case in entero-typhus.

As the disease under consideration is owing to a more or less irritated hyperæmic state of the intestinal mucous membrane, aloes and gamboge do not seem to be generally indicated in its treatment, from their stimulating effect upon the mucous membrane of the bowels, with which, moreover, they come in direct contact. Aloes, besides, accelerates the circulation of the blood, not unfrequently so as to give rise to hemorrhages, and would, therefore, not agree with an excited vascular system. It promotes, it is true, the hepatic and intestinal secretions, but only

when there is a torpid condition of the liver and a relaxed state of the bowels, and may, therefore, be adapted to torpid cases of remittent fever, which will occur but seldom, when the disease is subjected, in its early stages, to a wrong treatment. Dr. W. has used it as a stomachic, and once gave it, after the symptoms indicative of irritation had been pretty much allayed; he recollects that it very nearly caused a relapse of the disease. If an evacuation of the bowels is desired, the neutral salts, castor oil, or calomel will be the articles that will best agree with the patient. It is best, however, not to use any purgative before the general and local irritation have been relieved. To achieve this, warm fomentations or cataplasms, with cicuta and hyoscyamus to the abdomen; leeches, cups, the mercurial ointment, together with the oleum hyoscyami cortum, according to circumstances, should be applied, and the fever combated by the nitrate of soda given in some mucilaginous decoction, as, for instance, that of rad. altheæ. The nitrate of soda is preferable to the nitrate of potassa, being milder in its action. In simple cases it is sufficient to make warm applications externally, with warm mucilaginous drinks internally, and the aqua chlorata. The neutral mixture, or some purgative neutral salt, together with rhubarb, may be afterward used.

To the torpid cases, and those in which the local irritation has subsided, the antiphlogistic method is not applicable. The best remedies are, then, spir. minder., the muriate of ammonia, vin. ipecacuanhæ, the tartrate of potassa et soda, sulphate of magnesia in a decoction of rhubarb, the cream of tartar with rhubarb, and the oil of juniper, or spir. nitri. dulcis, according to the particular secretion that we desire to promote. Calomel should not be given in these cases. Dr. W. was called to a case of this kind in which calomel had been prescribed for four days without any good effect; it being suspended and quinia and rhubarb administered, the patient very soon recovered. In cases of ulceration of the bowels, our dependence is to be placed in the employment of tonics, such as nitrate of silver, muriate of iron, acetate of lead, tannic acid, together with opium and a carefully selected diet.

Adjourned.

A Hospital for Surgical Operations has been established in a beautiful rural site in the vicinity of Paris. The object is to give to patients about to undergo important operations a location where they will be removed from the crowded city, with its contaminated atmosphere, and where they will have the benefit of the most favorable hygienic surroundings. The design is a humane one, and, if sustained, will certainly be productive of great good to sufferers, for it is everywhere the experience that in large city hospitals the mortality after surgical operations is much greater than in private practice or in the smaller institutions.

EDITORIAL DEPARTMENT.

PERISCOPE.

Weekly Summary of American Medical Journalism.

By O. C. GIBBS, M.D.

TREATMENT OF FRACTURES OF LONG BONES BY SIMPLE EXTENSION.

Passing the article, by Douglass Bly, upon Amputation of the Lower Extremities, with reference to adaptation of artificial limbs, we come to consider an article by Dr. John Swinburne, of Albany, upon the treatment of fractures of long bones by simple extension. We regard this as one of the most important papers in the volume before us. The paper and its teachings will doubtless eventuate in the simplification of the dressings, and the better treatment of fractures. We shall give our readers a tolerably full synopsis of the paper, and may indulge in a remark or two, and perhaps a criticism.

The doctor assumes that, in treating fractures of all long bones, splints are useless, or even worse than useless, *except as a means to maintain extension*. This proposition is not so novel as would at first appear. To *maintain extension and prevent motion* at the point of fracture, are the ends to be secured by means of splints. Anything *more than* this, is useless. In the fracture of long bones we have very seldom used more than *one* splint. We *had not* supposed that simple extension was alone necessary to secure speedy and perfect union. We *had supposed* motion at the point of the fracture, however slight, would delay union; and that extension alone would not, *necessarily*, prevent this slight motion. The doctor says:—

"The true use of splints *should* be to keep the fractured ends of the bone in apposition, by placing the muscles on the stretch, and thereby making *them* (the muscles) the true splints."

The doctor assumes that a muscle cannot be extended beyond its normal capacity, and that "extended muscles act as permanent adjusters of broken bones."

When extension is complete, the muscles will, it is true, force the bone into line; and if that extension is maintained, and no other and opposing forces are brought to bear, the points of fracture will retain their apposition. Let the ex-

tension be ever so perfect, the unequal contraction of the muscles, (whether spasmodic or otherwise,) and any lateral force, it seems to us, might accomplish lateral motion—a swaying of the point of fracture—that must operate to retard union. These theoretical objections, of course, become null before positive facts of experience.

The doctor reports his experience as unusually favorable. His observation extends over a period of thirteen years, and he says:—

"In my experience, extension without splints, has never resulted in non-union, notwithstanding over one hundred cases of fractures of the various long bones have been treated by that method, while out of only twenty or thirty cases treated by splints, I have seen temporary non-union result in three instances."

Still further, he observes:—

"I have now treated over forty fractures of the femur and tibia, and in no instance have I seen over half an inch shortening, (and that was the result of inattention,) while in the larger majority there was no shortening at all, (this, of course, does not include inter-capsular fractures, where there is always more or less deformity,) nor were there any of these that resulted in a non-union."

Those surgeons who have declared that *some* shortening follows in all cases of fracture of the femur, may be a little skeptical in regard to so perfect a success. For our own part, we cannot see how extension *without splints* can give better results than *appropriate extension maintained by aid of splints*! Extension *with the possibility* of motion at the point of fracture, better than extension *without such possibility*! But it matters not whether the *wherefore* of the result is perceptible by us or not, providing the fact is as stated. The doctor says:—

"If we can treat any fracture occurring in the leg or thigh, from the hip to the foot, simply by a perineal belt and extension from the foot, *without any splints*, and make better results, with more comfort to the patient, and with more speedy recovery of the use of the limb, we have surely arrived at the grand desideratum; and when the treatment of fracture of the arm or forearm is rendered equally as simple, we have, I apprehend, arrived at the 'ultima Thule.' As for myself, I employ this treatment indiscriminately, and I only ask my professional brethren who have the opportunity to try it, to do the same, and I am sure they will be able and willing cheerfully to bear witness to its entire efficiency, as have my friends Drs. Thorn, of Troy; McLean, of the Marshall Infirmary; Whitbeck, of West Troy; and Willard, of this city. I am positive that the method will withstand the most searching tests, and that it challenges comparison with

the results of the most complex machinery of splints and bandages."

In cases of fracture, at any point between the hip-joint and ankle, if dressed *without splints*, the perineal belt is fastened at the head of the bed, and the foot is fixed in its extension at the foot of the bed. It would seem to us, that this would necessitate a confinement to a bed much longer than would be necessary, providing the extension was maintained by means of a light and appropriate splint. In "hip disease" the various splints recently invented can be dispensed with by appropriate extension upon the bed; but this would be no improvement, for in that case the painfulness of a fixed position would have to be endured and the comforts of exercise foregone. Notwithstanding the positive assertion of Dr. Swinburne, that no splints were used in the treatment of the case reported, we fail to see it so. It seems to us he plays upon a word. He may not use a splint, as such by name, but he makes a *splint of the bedstead, and the bedding is but the padding*. If he can make us believe that a bedstead is lighter and more convenient than a light, ingeniously-devised, and well-applied splint, then we yield to him all he claims. In ordinary cases of fracture, between the points mentioned, at least a majority of such fractures, where and as they occur, if an ingenious splint is well applied, the patient may be off the bed in two or three weeks; if of the leg, they need not be confined there at all. By Dr. Swinburne's so-called improved method, the patient must be confined to the bed for months.

But as an offset to this objection, he says:—

"The patient can move about in the bed as much as is necessary with greater freedom than when embarrassed by a long splint, and with really less danger of displacement. The seat of fracture can be examined at any moment without having a long bandage to unroll, and wet cloths or other local applications can be used with as great facility as if the limb were well."

Many other advantages are mentioned, for which we have no space; but let us consider this freedom of motion on the part of the patient, without "danger of displacement." The broken limb is extended virtually from its two extremities, and fixed at a certain point. The upper portion of the fracture is connected to the body, and must respond more or less to *its motions*. If the patient turns from the position upon the back to his side, will the lower fragment, extended as it is and firmly fixed at the foot, respond per-

fectly to the change of position? It would seem to us that the limb above the fracture would respond to the motion of the body, and the lower portion remain in statu quo—the fractured surfaces moving on themselves, especially in the early stages, thus preventing union, and, in case of final success, endangering inversion or eversion of the foot. It is true, great pain would doubtless deter the patient from effecting this change of position and its consequences; but who can endure a position upon the back constantly for months? Except in cases of fracture within the capsular ligament, or perhaps of the upper half of the thigh, we should certainly decide in favor of the adjustment of an appropriate splint over this bed-fastened condition. Certainly, in cases of fracture of the arm, the patient is not to be fastened to a bedstead—some splint-like arrangement must be instituted to maintain the extension.

A few weeks after Dr. Swinburne read his paper before the Medical Society of the State of New York, it was published in the *American Medical Times*. We observe the paper as published in the *Times* and as published in the *Transactions*, are slightly different. We would claim for any author the right to change his paper from the time of reading to that of publication, as to matters of style, but would deny to him the right to change the facts. We suppose the facts of the author's experience were correctly given in the paper as read. Was the first publication a transcript of that, and published by his consent? If so, was the paper in the *Transactions* revised by him? We make two quotations—first from the *Transactions*, second from the *Times*.

"In fractures of the inferior extremities, the patient, of necessity, is obliged to keep his bed, and hence there is less demand for comely appliances than in cases of fracture of the arm or forearm. In fracture of the femur, I use simply extension and *counter-extension without splints*, and in the leg I sometimes do the same, making use of the following plan, by which the extension and counter-extension is effected. The patient is placed in bed, and a broad, well-padded perineal belt, made from one and a half to two and a half inches in diameter where it comes in contact with the perineum, (in order more fully to equalize the pressure,) is adjusted as indicated in the plate, so that the line of extension shall be through the long axis of the femur.

"It may be stated that one important object of extension, not mentioned before, is to overcome the otherwise distorting influence of the adductor muscles.

"This perineal belt is secured to the head of

the bedstead, and no splint at all is made use of, as the powerful muscles and fascia that envelop the femur are amply competent to support and fix the bone. The pelvis being thus fixed by the perineal belt, extension is obtained by means of adhesive strips secured to the leg. The plasters are cut proportionally to the size of the limb, from one-half to one inch in breadth, and of sufficient length to be applied along the outside of the leg, descending spirally, protruding so as to form a strong loop under the sole of the foot, and then extending up on the inside of the leg. These strips are not applied one directly over the other, but at small distances apart, so as to embrace a larger surface of the leg, thus equalizing the tension upon the integument. Then a number of shorter strips are applied in a manner similar to the many-tailed bandage, surrounding and securing the long plasters against possible detachment. The shorter strips are not indispensable, as the same end may be attained by a simple roller." (See *Transactions*, page 115.)

"In fractures of the inferior extremities, the patient, of necessity, is obliged to keep his bed, and hence there is less demand for comely appliances than in cases of fracture of the arm or forearm. In fracture of the femur, I use simply extension and counter-extension without splints, and in the leg I sometimes do the same. At other times I effect extension and counter-extension through the medium of a *delicate splint*, and an equally *delicate foot-piece* fastened to the foot by means of strips of adhesive plaster, while the counter-extension is made from the knee by adhesive plaster looped about the limb below the joint. Then, by means of a strong cord passed through this loop, and thence through a hole in the *side splint* some distance above the knee, the requisite extension can easily be made to any desired degree. If, after full extension is effected, it should appear that the limb is not sufficiently steady at the seat of the fracture, the application of strips of plaster around the limb and splint, at intervals of three or four inches, will accomplish all the indications. If the fracture of the leg happens to be near the knee-joint, I am in the habit of using the perineal belt, made large, full, and easy, as in fracture of the thigh." (See *American Medical Times*, vol. ii. page 145.)

Much more is said here in regard to the treatment of various fractures and the use of splints, which is entirely left out in the paper as it stands in the *Transactions*. "Extending-splints," "side-splints," "double-inclined planes," etc. are referred to as being used by him.

When he says he has treated fractures thus for thirteen years with the best of results, which are we to believe? In one paper he dispenses with splints, he says, entirely, and in the other he acknowledges their use in all cases except in fracture of the femur, and then he makes a splint of the bed, for he says:—

"The fractures of the superior extremities are subject to the same laws, and hence require the application of the same principles. But, owing to the fact that the patient is not confined to the bed, the extension and counter-extension are necessarily made through the *medium of a splint*, while, in the lower extremities, the *bed is the splint*, the foot of the bedstead the point of extension, and the head-piece the counter-extending point."

That Dr. Swinburne has treated fractures for thirteen years entirely without splints, as we are led to infer from his paper in the *Transactions*, and with unparalleled results, we are disposed to doubt, and our doubt is based upon his paper as published in the *Times*.

We would not be understood as wanting in appreciation of Dr. Swinburne's labors toward simplification of the treatment of fracture, or of his written defense and exposition of his method of treatment. We agree with him that extension is all-important; that the muscles, in a state of tension, will necessarily fix the fractured extremities in position; but, at the same time, we believe that an appropriate and properly-adjusted splint is the best means of maintaining this extension; and, more, that a splint is almost, if not quite, a necessity to guard against motion at the point of fracture.

The splints used by the doctor may be more "delicate" than any in use, and in his hands lateral movement possibly may be prevented by adhesive plasters; but this no more makes splints of muscles than does the common splint in the hands of other surgeons. If, in his hands, "the *bed is the splint*," we cannot see how this differs in principle, or effect, from the common straight splint so often used in such cases; besides, if we rightly understand the matter, the patient is confined longer, and to a more immovable position, than under the most approved methods now in use by the best surgeons.

We hail with unbounded satisfaction all improvements in medicine or surgery, and we have no doubt that Dr. Swinburne's paper will be productive of good, in inviting surgeons to dispense with cumbersome apparatus. Our criticism has been made rather to caution the inexperienced against too hastily throwing aside splints, and trusting altogether to muscles. Broken bones are too prolific a cause for damage suits even now, and in effect, Dr. Swinburne does not dispense with *distending* and retaining apparatus.

The doctor's paper, however, is not without great interest, and we think and hope it will be productive of good results. He presents very clearly the objects to be secured by all dressings in cases of fracture, and the effect will doubtless be a simpler dressing in all such cases, and better results. There is, however, no novelty about his principles—extension and immobility we have ever had prominently before us in the treatment of fractures, and we seldom use more than one splint in the accomplishment of these ends. That Dr. Swinburne often uses two or more, his article in the *Times* fully attests.

Before quitting this subject, we will refer to what seems to us a discrepancy in Dr. Swinburne's statement. His first and main proposition is, "that a muscle cannot be extended beyond its normal capacity," which, from the context, we suppose means natural position. We suppose he means to say that, in securing extension, there is no fear of separating the fractured extremities by too great extension, for a "strong man" can only "stretch the muscles to their normal length," and "any attempt to go beyond this not only provokes resistance, but a tearing of the muscle." While objecting to a recently proposed treatment of fractures, by *elastic* extending and counter-extending bands with weights and pulleys, his third objection is: "Were there to be applied a *trifle too much* weight, the object would be defeated by *absolute separation* of the bone." Now muscles *can* be extended beyond their normal capacity, or they *cannot*. If they can be, the doctor's first and main proposition is lost; if they cannot, his third objection has no weight.

It is possible we fail to appreciate the doctor's meaning in some particulars, and, if so, we claim for ourselves an honesty of intent. Our criticisms have been made in no spirit of invidiousness or sensoriousness. We have a high opinion of Dr. Swinburne, and of the intent and influence of his paper. An honest criticism we regard as productive of good, and in no way objectionable—it provokes thought, and leads to the development of truth.

We conclude our notice of this paper with one additional extract, which we regard as having practical interest:—

"The method of extension is extremely simple, and can be carried out by any surgeon who can measure from the anterior spinous process to either malleolus. As I am daily asked many questions concerning it, I give here a brief resumé:—

"1. I have the perineal belt made *large* and

easy, to draw in the line of the axis of the bone. Moderate extension is made sufficiently to maintain the muscles firmly on the stretch, until the soreness of the bruised limb has abated, and the patient become accustomed to the confinement; when firm extension is made, until the limb is drawn out so as, by absolute measurement, to equal the length of its fellow.

"2. I maintain this extension until union is moderately strong. In cases where time is of no importance, I keep the patient in this condition until there is no danger of any refracture. In those where time is of much importance, I apply a roller, and some split deal or pieces of cigar-box around the limb, moderately tight, so as to keep the bones firm, but not sufficient to constrict the limb. The patient can then sit up or walk with crutches. This is removed as soon as I feel assured of the firmness of the bone, and generally from seven to eight weeks is sufficient for this. In this condition (where union is firm enough to prevent any shortening) I find the starched bandage of special service, particularly where *time* is the grand desideratum."

We said we would conclude our notice with the above extract, but, really, we cannot yet quit the subject. The doctor evidently sees the importance of splints when he says:—

"Though I firmly believe that all fractures of the leg can be treated without splints as successfully as with them, and that the same treatment is as applicable to them as to those of the thigh, still, as a matter of comfort, where the fracture is transverse, and there is no overlapping of the bones, lateral support is admissible, if it can be applied without causing constriction of the parts, because it does not render rigid confinement to the bed necessary."

Dr. Swinburne concludes his paper, so far as his opinions are concerned, by illustrating the methods of dressing the various kinds of fracture. Suffice it to say, with the exception above made, a splint is used in the case of each fracture referred to. While we deny that Dr. Swinburne's treatment of fractures is without splints, we are willing to confess that, aside from the leg, his illustrated treatment we regard as the very best known.

To say that he treats fractures without splints, is to say what is not true; that he altogether dispenses with *side support*, is also untrue. The following extract we consider as giving the gist of his paper:—

"I have endeavored to demonstrate that it is not the *kind* of splint used by the surgeon, so much as the *principle* involved and the faithfulness with which it is carried out, that renders the treatment successful; and I think it matters little whether we make the bed the means by which

extension and counter-extension is effected, or use a stick, round, flat, or of any other form, so long as the requisite length of the limb is maintained. When it is so maintained, the limb will always be straight and perfect. I do not consider the apparatus as necessary for side support or coaptation at all, *but it is more convenient, is easily made, is light, and does not constrict the limb in the slightest degree.*"

We do not see how it can be determined whether "side support" is "necessary" or not, providing it be *always used* because more "convenient."

As before stated, we regard the maintenance of extension and of inflexible side support as all that is necessary to the successful treatment of fractures. In these particulars we perfectly agree with Dr. Swinburne. We do not, however, agree in the propriety, safety, convenience, or comfort of the entire dispensing with splints.

If our notice shall induce our readers to read Dr. Swinburne's paper, we shall have accomplished one of our objects in this critical summary, and we have no doubt but that good will result from such reading.

The doctor quotes Drs. Thorn, Whitbeck, Young, Willard, and Craig as agreeing with him in opinions and in practice. Dr. Thorn gives a few conclusions which we consider of sufficient importance to subjoin:—

"1st. Since I have adopted the plan of treating fractures of the femur by extension without splints, I have found no difficulty in maintaining reduction and apposition of the fractured end of the bone. When I used splints I frequently found great difficulty.

"2d. I have found that simple extension answers all the requirements in treatment of this form of fractures.

"3d. My experience is that the chances of distortion or shortening are very little by the extension treatment, as compared with the use of splints.

"4th. I have found the extension treatment applicable to all fractures of the thigh, within the capsular ligament or not.

"5th. I have found that the muscles recover their use much sooner under the extension treatment than they do when splints are used.

"6th. I feel much more easy as to the results, while the limb is under treatment with simple extension than with the use of splints.

"7th. As regards the ease and comfort of the patient, it is very much in favor of simple extension.

"8th. I have treated and seen the treatment of fifteen cases of fracture of the femur by simple extension, and they compare very favorably indeed with treatment by splints.

"9th. I have never seen a case of non-union of the femur.

"10th. My experience, in fracture of the tibia and fibula, is favorable for extension, when it is required. I have lately had under treatment a case of compound and comminuted fracture of leg, where the extension came up to the most sanguine expectation, and the result was good."

RECOVERY FROM SUSPENDED ANIMATION AFTER CHLOROFORM.

The next article is by Dr. T. G. Thomas, under the above heading. He reports a case in which life seemed to have become extinct for at least twenty minutes, that was restored by means of artificial respiration. Chloroform had been inhaled, and death seemed imminent; but by means of artificial respiration the danger was obviated, and death averted.

The case was one of those unexpected and alarming ones that call for prompt and decided action, firmness, and discretion. The pulse and respiration ceased suddenly when not more than two or three drachms of chloroform had been inhaled. Artificial respiration was carried on for twenty minutes before the least signs of life were discoverable. At this juncture a galvanic battery was brought into requisition, and the neck, pectoral muscles, the region of the diaphragm, etc. were subjected to its influence.

"Instantly the muscles jerked, as if in convulsion; the eyelids flew open, the head was jerked back, respiration was soon established, and in ten minutes more I had the inexpressible satisfaction of seeing the patient out of danger."

In cases of suspended animation from chloroform, opium, etc. we have no doubt of the propriety and utility of the galvanic battery. It should never be neglected where death is imminent under these circumstances.

COMPLETE INVERSIO UTERI REDUCED.

In the next paper Dr. A. Van Dyck reports a case in which inversion of the uterus took place on the eighth day after delivery. The case was quite unusual in its character, and quite satisfactory in its results. The doctor replaced the uterus at the first attempt. The replacement evidently commenced at the neck. In the *completion*, "the fundus was dimpled, and thus carried through the os and cervix uteri." From this language, except the slight dimpling, we doubt whether the replacement was not from the neck toward the fundus, as we suppose it is in nine

cases in ten. For our views upon inversion of the uterus and its replacement, we beg leave to refer our readers to the *REPORTER* for July 6th, 1861, vol. vi. p. 318 and seq.

RUPTURE OF THE UTERUS.

Passing the next paper, in which a case of rupture of the womb is reported, complicated with an enormous umbilical hernia in a state of gangrene, in which the mother and child both died, though the child was removed by abdominal section by Dr. C. V. Barnett, and also a case of fibrous polypus, reported by Dr. G. A. Dayton, which resulted in death after removal, we come to an article upon Rupture of the Uterus, by Dr. G. J. Fisher. The doctor has seen three cases within the preceding two years, all Irish women, and occurring within the distance of a mile. The doctor makes the following practical remarks:—

"I have arrived at the conclusion that should any other cases ever occur in my practice, (which God forbid,) I should not delay in resorting to the abdominal section, unless the labor could be effected in a very brief time and with the greatest facility. I believe that in nearly every case it would increase the chances of recovery to resort to this procedure, unless the vital powers were extremely depressed, as in the third case.

"The danger of opening the abdomen is not as great as many apprehend. It is a bloodless operation, simple, quickly and easily done. The great advantage appears to me to consist in the entire removal of the blood from the peritoneal cavity, and leaving the surfaces clean."

Notwithstanding high authority has recommended it, we have always wondered that any physician could leave a case of ruptured uterus *to nature*, or would, in case of an entire escape of the child into the abdominal cavity, introduce the hand into the uterus, pass it through the laceration, seize the feet, and deliver through the uterus and natural passages. After the child has escaped into the abdominal cavity, of course its delivery is not to be expected from the efforts of nature; with its escape into the abdomen, the uterus contracts and the dimension of the rent is lessened. To return the child through the uterus requires the rent to be again dilated or increased in dimensions. We can scarcely imagine how a patient could recover thus delivered. In a case of rupture of the uterus, and the escape of the child into the abdominal cavity, there must be a free escape of blood into that cavity. Its removal is impossible by any aid the physician can render

through the natural passages, and in the process of recovery the contraction of the uterus must prevent its escape by the natural passages. Such escape of blood, confined and prevented from escape, we would suppose would develop an inflammation that would be fatal. By the abdominal section there is, in addition to the laceration, the danger arising from the incision. But for this additional danger, we may get rid of the child without injury to the uterus, or the passages involved in natural labor, and besides, we may cleanse the abdominal cavity of all blood or other foreign substances that may have been received therein from the womb. To us the abdominal section, in cases of rupture of the uterus and escape of the child through the rent, seems by far the more promising procedure for both mother and child.

REMARKABLE CASE OF SUPPRESSION OF URINE.

Passing the next three papers, we find the report of a singular case. The report is made by Dr. A. G. Purdy, and we quote it entire:—

"Miss A. P., of Lenox, Madison County, New York, aged about thirty-six, is the subject of a long-continued and complete suppression of urine. Her physicians, nurses, parents, and neighbors all concur in the statement that for about six years the suppression has been complete. It is not known that she has voided one drop of urine during the period mentioned. Previous to a complete suppression, Miss P. was, from some cause which we did not learn, compelled to use a catheter at first, daily, then at longer intervals, until the periods gradually lengthened so that two months would intervene. The urine at such time was dark and thick like the sediment of coffee. Miss P. presents a singular appearance; her face once fair, is now black, with the exception of upper lip, and from the corners of her mouth down. Her left arm and leg are also black. The change of color commenced on her left hand at or near the time the use of catheter was discontinued. The discolored portion appears as if covered with a thin coat of dry, black blood. Occasionally, small quantities of blood ooze through the skin. Catamenia ceased about four years since. Dr. W., formerly her physician, says he has seen her expectorate, during a paroxysm of coughing, a substance strongly resembling charcoal. We learned on Monday of this week, from Miss P. and her patients, that for eight weeks past she has not had an evacuation from her bowels. The covering of her face is not continuous but broken, resembling scales which touch without overlapping. The black surface has considerable lustre. I cannot say there is no deception in this case, but think the above statement substantially correct."

AMPUTATION OF THE CERVIX UTERI.

Passing the next 175 pages, in which we find but little of *practical* interest, we come to the concluding paper, upon the above subject, by J. Marion Sims, M.D. Dr. Sims reports two cases in which a new method of amputation was adopted. He says:—

"On beginning the operation, I intended to leave the cut surface to heal by the granulating process, which usually takes five or six weeks; but while sponging the wound and waiting for the hemorrhage to cease, I discovered that the stump could be covered over with healthy vaginal tissue, in the same manner that a stump of an arm or a leg is covered over with skin after amputation by the circular method. This was done by passing four sutures of silver wire through the anterior and posterior borders of the wound, which, when tightly drawn, brought its edges into apposition in a straight line across the middle of the stump, covering it completely, but leaving a small central opening for the os, just over the outlet of the cervical canal."

Remarking upon the second case, he says:—

"The operation was performed as in the preceding cases—namely, by splitting the cervix laterally, and removing first, the anterior, and then the posterior half, by means of scissors. After the hemorrhage had ceased, the vaginal mucous membrane was drawn over the stump, as in the other cases, and secured by four silver sutures, two on each side of the cervical opening. There was no suppuration, no pain, no febrile excitement, and, indeed, the patient felt so well that, on the next day, she insisted on getting out of bed and going to the parlor; for prudential reasons, however, she was confined to her room a week. Here was a case which had been under treatment for fifteen months at various times, with little improvement, cured in a week by this simple operation. The neck of the uterus now presents an appearance so normal that one could hardly believe that it had ever been the subject of disease or of a surgical operation."

"In the old method of amputation, the suppuration continued for five or six weeks, and sometimes longer, before the parts were entirely cicatrized. According to this plan, there is no suppuration, the parts healing by the first intention and the patient becoming well in a week. In the former, there was danger of pyemia; in this, there is little, if any. In the former, there was risk of degeneration in tissue; in this, there is none. In the former, the parts contracted as they healed; in this, they remain normal. It might have been supposed, *priori*, that this operation would have been attended with troublesome hemorrhage; but in each case it ceased as soon as the vaginal tissue was drawn over the stump, and in no instance was a ligature used. In all three of the cases menstruation has been easy since the operation, though the os was

smaller in each than natural, and required to be enlarged by slight incisions."

We conclude our notice of the volume before us with the observation that the *Medical Society of the State of New York* is a working Society, and its annual volume of *Transactions* is worthy a place in the library of any intelligent physician who is in search of all there is progressive in his art. May prosperity and success attend this Society, and we shall hope to benefit by the perusal of its *Transactions* for many years to come.

THE MEDICAL AND SURGICAL REPORTER.

PHILADELPHIA, SATURDAY, APRIL 26, 1862.

HYGIENIC PRECAUTIONS IN WARM CLIMATES.

There has been a good deal of apprehension in the loyal, and an expectation in the insurgent States, that the armies of the Union will, if the contest is prolonged until the weather becomes warm, find it impossible to maintain their foothold in the Gulf States, on account of the prevalence of diseases incident to a climate and a temperature to which they are wholly unaccustomed. It is feared on the one hand, and hoped on the other, that the constitutions of the Northern troops will give way before the enervating influences of a climate to which they are unaccustomed, and to some of the forms of pestilential disease which prevail in some parts of the Southern States, and that "the pestilence which walketh in darkness" will aid "the destruction that wasteth at noonday" in defeating the national forces, and driving them from that section of the country.

All this may be so; but if it is, it will be in great part from neglect of adopting proper sanitary precautions, and the medical staff of the army will be in a great degree responsible. It by no means follows that a constitution accustomed to a colder, cannot adapt itself to a warmer climate. This, if judicious sanitary rules are enjoined and strictly observed, it readily does. The experience of the past, we believe, goes to show that there is much more danger from the change from a hot to a cold climate than the reverse. Napoleon's Egyptian army did not suffer a tithe what the army did during the Russian campaign. From all accounts, the campaign of the past winter was very disastrous

to the troops from the Gulf States, who came only so far north as Virginia and Kentucky. But there is testimony to show that in campaigns in high latitudes, troops from colder countries are even more healthy than those from adjacent regions. Thus, Gen. Hunter, commandant of the Department of the South, embracing the States of South Carolina, Georgia, and Florida, in an order, a portion of which is published on another page, says:—

“During our war with Mexico, the soldiers of New England, the Northwestern, and Middle States, and the adopted citizens serving in our army, suffered far less from the diseases incident to a semi-tropical climate, than did the soldiers from the States embraced in this Department.”

The order alluded to is a very important one, as bearing on the health of the troops in the Southern Department of the Army, and comprises some excellent rules and observations. Yet there are some minor precautions which are of considerable importance, which the brigade and regimental surgeons should impress on the minds of the troops. Some of these are: 1. The clothing should not be too thin. Flannel should be worn next the skin. Pickets, and others who may be exposed to the *night air*, should especially observe this precaution. Improper exposure to the evening and night air is the cause of a vast amount of sickness in warm climates. 2. The soldiers should be cautioned not to *bathe too frequently*, especially when they are heated and fatigued by long marches and other exertion. 3. They should be particularly cautioned against eating unripe fruit. The temptation will be great, but it should be a matter of strict discipline that it be avoided. Thoroughly ripe fruit should be moderately eaten. 4. Drinking cold water when heated, and drinking stagnant water should be cautioned against. 5. We should be disposed to *banish the spirit rations altogether*, except in cases where an evident low vitality requires stimulation. 6. When practicable, wet clothing, *especially at night*, should be removed and dried. 7. It must not be forgotten that in hot climates the pestilence, as the Psalmist beautifully expresses it, “*walketh in darkness*.” Therefore, avoid the night air; or, at least, be well protected against it, should be the line upon line, and precept upon precept inculcated by the medical officers of the army—not indeed alone in the Southern, but in all the military departments.

Dr. Livingstone traversed the sickly wilds of Central Africa with “the Bible in one hand and a bottle of quinine in the other,” and escaped the prevalent African fevers. If our troops will be guided by the religion and morality laid down in the one, and the sanitary precautions represented in the other, there is no reason why the Southern Department of the National Army should not be as healthy as any other. Indeed, if the very judicious rules laid down in the order published on another page, and the suggestions made in this article are strictly carried out, there will be very little sickness heard of in that department. Even yellow fever could hardly stand such regulations.

NEGLECT OF THE WOUNDED ON THE BATTLE-FIELD.

Among the many sad realities of war, none is more sad than that of the frequent neglect of the wounded on the battle-field. The causes of this neglect are various. The rage of battle, and the varying fortunes of war, by which the battle-ground is sometimes held alternately by one and the other of the opposing forces, and the consequent impossibility of either securing and caring for all the wounded, is one. But there is another cause, which might often be provided against where great battles are impending, and that is, an insufficient supply of surgical aid and appliances. The surgical corps of an army, while equal to any ordinary emergencies, are not equal to the demands of a great battle; consequently, at such times, the wounded are frequently left to suffer and die for lack of a little timely aid which might easily have been rendered by a surgeon or even an intelligent nurse.

For some time arrangements have been made by which a large number of surgeons are to be summoned from this and the contiguous States, to aid in caring for the wounded in the impending battle between the two armies of the Potomac. It is anticipated that this, when it occurs, will be a terrible and decisive battle, and, of course, there is expected to be a vast amount of surgery to perform. It is to be hoped that, when the battle does take place, the surgeons will have the opportunity of being on the spot *at the time*, and not have from one to three days' journey to take after it occurs.

Besides the positive neglect of the wounded in the circumstances referred to above, needless operations are sometimes performed by surgeons,

in the hurry and excitement that ensue. The great pressure of business prevents his exercising that coolness and judgment which is necessary to a proper performance of his duties. We lately heard of an instance where an arm was amputated on the battle-field, and a subsequent dissection showed that the ball passed *between* the bones of the arm without in the least injuring either! The importance of life and limb should insure the utmost deliberation in the performance of operations after battles; and to this end, there should always be an adequate surgical force close at hand in all cases of impending battles.

Our army at the battle near Pittsburg Landing, Tennessee, seems, in many respects, to have been taken completely by surprise; but in none more than in the very inadequate provision made for the wounded when a battle did occur. What were 80,000 men there for, within a few miles of an enemy of equal or superior numbers, but to fight? And yet, when the day of battle came—the most severely-contested and extensive, probably, that was ever fought on this continent—surgeons, nurses, and hospital stores had to be sent all the way from Cincinnati, Louisville, and St. Louis! Surely, when two such vast armies were facing each other, it was a dictate alike of prudence and humanity to have some adequate provision for the care of those heroes who should fall in the service of their country.

This battle occurred on the sixth and seventh of April. On the twelfth, a correspondent of a Western paper writes as follows:—

"The horror of horrors connected with this battle, is the treatment of the wounded. In the first place, there were poor facilities for treating them; and in the second place, there were not a fifth enough surgeons to attend to them. I would gladly draw a veil over the horrors on this point, but duty to our gallant volunteers demands that the truth be told. A large number of the wounded had crawled or been carried to the bluff opposite the landing on Sunday and Monday. Some found the shelter of tents, but others lay out in the open air. There those men lay, without a surgeon or attendant, without a mouthful to eat or drink, until Wednesday morning.

"They groaned and died with no one near to pity them, and the dead and the dying lay there together. On Wednesday morning one surgeon was sent to them, and one attendant with hard crackers and water! And that was their treatment until they either died or were conveyed to one of the boats which presently came to the relief of the wounded.

"At present, nearly a week after the battle, many of the wounded are not fully cared for.

They are lying about in tents, upon straw, with no nourishment, and exposed to the weather. Several boat loads have been shipped away; but still many, very many, are here. I now write in the cabin of the Tycoon, with four rows of them in front of me.

"Our boat, the first one of the Cincinnati Sanitary Commission, arrived at three o'clock. By eight o'clock her cabin, her guards, and her decks were filled with the wounded. How thankful the poor fellows were when laid on soft beds, between clean sheets, and stimulated by nourishing diet! They forgot their wounds, their pains and hurts, and laid down and sweetly slept."

We trust that the commanding generals will see to it, as Gen. McClellan has done, in the Army of the Potomac, that ample provision is made for surgical aid and appliances for the wounded in any future battle that may occur.

HALL OF THE COLLEGE OF PHYSICIANS.

It was announced some time since in these pages that the late Professor Mütter had bequeathed the sum of \$30,000 and his museum to the College of Physicians of this city, on condition that a lot be secured and a building erected for the accommodation of the museum, a library, lecture-room, etc., within a specified time. We stated, also, that the legacy had been accepted and a lot secured.

It is with unfeigned satisfaction that we now announce that the work on the building is about to commence. The structure—which will be located on the northeast corner of Thirteenth and Locust Streets—is to have a front of fifty-five feet on Locust Street, and of one hundred and seven feet on Thirteenth Street; the material used to be pressed brick, with granite dressings. It is to be of the Romanesque style of architecture, to be built completely fire-proof, and the principal rooms will be for the museum, library, and meeting hall. The plans were furnished by Mr. James H. Windrein, architect, who will superintend the work. Mr. Michael Errickson is the builder.

The erection of this building will provide for the profession of the City of Philadelphia what we have for many years advocated in these pages, viz., a place of common resort for medical men—a medical exchange—where they can meet in pleasant and profitable social intercourse; where may be found the medical periodical and other publications of the day; and where lectures on

special departments of medicine and on the collateral sciences may be regularly delivered. Its erection will also give an impetus to the medical organizations of the city.

We therefore regard the establishment of this hall as the beginning of a new era in the history of medicine in this city. The medical profession of Philadelphia stands deservedly high throughout the country now, and this action of the College of Physicians will tend to raise it still higher.

The College has long had it in contemplation to erect a building for its accommodation, and had collected a considerable sum for the purpose before the bequest of Dr. Mütter was made. This sum will, of course, be added to the bequest, and without doubt an additional amount will be secured. Indeed, this building will doubtless be a nucleus around which contributions in money, pathological and other valuable specimens, books, etc. etc. will collect, and thereby confer a lasting and incalculable benefit on the profession of the city and the country.

EDITORIAL NOTES AND COMMENTS.

The Medical Department of the Army.—The act to reorganize and increase the efficiency of the medical department of the army adds to the present corps ten surgeons and ten assistant-surgeons, twenty medical cadets, and as many hospital stewards as the Surgeon-General may consider necessary.

The surgeon-general to be appointed by this law is to have the rank, pay, and emoluments of a brigadier-general. There is to be one assistant-surgeon-general, and one medical inspector-general of hospitals, the latter to have supervisory control of the sanitary condition of the army. Besides, there are to be eight medical inspectors, charged with the duty of inspecting the sanitary condition of transports, quarters, and camps of the field and general hospitals. The appointments to be made by the President, either from the regular or volunteer surgeons, with a sole regard to qualification.

Provision for the Wounded.—The entire new building of St. Joseph's Hospital has been taken by Surgeon-General Smith for the accommodation of the wounded Pennsylvania Volunteers. Assistant-Surgeon J. B. Crawford, of Wyoming,

and J. L. Marbourg, of Johnstown, with Cadets King and Barton, have charge of the wards under the orders of the Surgeon-General. The wounded were brought from Winchester, placed on beds in freight cars, to this city, without change of cars, and bore the transportation remarkably well. Future wounded are to be cared for in like manner. Why should not similar action be taken by each State located sufficiently near the scene of action to enable the wounded to be moved with safety?

Compulsory Vaccination.—A meeting of the New York Sanitary Association was held at the Cooper Institute recently, Mr. R. H. McCurdy in the Chair. The subject for discussion was the following resolution, proposed last meeting:—

"Resolved, That, in the judgment of this Association, further State legislation is imperatively required to secure a more general and effective vaccination, but so framed as to avoid offensive compulsion if possible."

The subject was extensively discussed, and the resolutions proposed are exceedingly important, as suggesting a method by which thorough vaccination and revaccination may be secured, without resorting to an offensive compulsory law requiring it. The resolutions, it will be observed, make an appeal to all the important interests of the city, and place the matter upon the ground of a sanitary regulation, which no class can disregard with impunity.

After much discussion by Drs. Bell, Louies, Griscom, and others, the subject was deferred till next meeting. Dr. Louies offered the following resolutions, which were seconded by Prosper N. Wetmore, and laid over till next meeting for discussion:—

"Whereas, This Association, after mature deliberation, has become convinced that vaccination and revaccination, as often as every seven years, is necessary to protect this community against small-pox; therefore,

"Resolved, That, in the judgment of this Association, further State and other legislation is imperatively required to secure a more general and effective vaccination, but so framed as to avoid offensive compulsion if possible."

"Resolved, That we petition the Board of Education or the Legislature, or whatever body is necessary, to pass and enforce an ordinance prohibiting the attendance, in all the schools receiving any part of the public moneys, of any children who have not been well vaccinated or variolated within seven years, or who cannot show a valid certificate to that effect, giving the date of the

vaccination or variolation; and after a proper period of public notice, to prohibit the tuition of any children coming from any family where all the other members of that family above the age of three months cannot prove or show a valid certificate of vaccination within that time, or of former variolation.

"Resolved, That we petition the Metropolitan Police Commission to cause all policemen or others under their employ, or receiving any benefit from their department, such as lodging, etc., to be vaccinated, or show a valid certificate or proof of vaccination or variolation within seven years.

"Resolved, That we take measures for the passage of a law compelling the vaccination of every prisoner, and of his or her vaccination shortly before discharge, provided the term of incarceration shall be prolonged more than two years from the time of former vaccination.

"Resolved, That we petition the Commissioners of Charities and Correction, as well as all other public bodies having the care of the poor, to comply with the above rule in all institutions under them, and to withhold all in or out-door relief of any kind until vaccination is performed, or the dates of previous vaccination ascertained.

"Resolved, That we recommend to the Legislature to make the same a feature of all chartered institutions.

"Resolved, That we believe that the Dispensaries and Police and Prison physicians are fully capable of vaccinating all in this city who are not able to afford to pay a responsible physician.

"Resolved, That it be made necessary that every person affected by the above ordinances shall be required to procure and preserve a vaccine certificate, properly filled out and dated.

"Resolved, That we recommend the appointment of a general Vaccine Board to attend to the inspection of vaccinations and certificates.

"Resolved, That we believe that the above withholding of all public benefits and offices from all the families of this city would in the course of a few months, without any compulsory law at all, cause the vaccination of nineteen-twentieths of the citizens of New York.

"Resolved, That we recommend the adoption of the above rules to all other charitable bodies or institutions, schools or asylums.

"Resolved, That a committee be appointed to carry out the above petitions."

Dr. John H. Griscom offered the following resolution to be referred to the committee of three already appointed to act on the same subject:—

"Resolved, In the consideration and dangerous character, and the prevalence among various classes of syphilitic disease, that, in the judgment of this Association, the source of said disease should be placed by law under strict medical police supervision."

CORRESPONDENCE.

Domestic Correspondence.

TREATMENT OF EPILEPSY.

PHILADELPHIA, April, 1862.

MESSRS. EDITORS:—While in general practice for many years in the City of Boston, my attention was specially given to the pathology and treatment of nervous diseases.

It is well known that in the arts and sciences a division of labor facilitates the operations and tends to perfection in every department. The same principle has long been recognized, in a degree, in the medical profession; hence one man devotes himself to surgery, another to dentistry, another to the treatment of the insane, another to general practice, etc. This is undoubtedly wise, for no one man can attend to everything; and life is too short to be spent in attempting to search out all sciences or practice all professions.

Still, as it respects *specialties* in medical practice, a word ought to be said to guard against abuse in such practice. It is this: no man is likely to be, can be, versed in special practice who has not been thoroughly educated as a physician; and in addition to such an education, some general practice ought ordinarily to precede the special.

So far as the writer is aware, the profession have no objection to a *specialty*, when guarded or preceded by such a course of study and practice; but, on the contrary, approve it.

Some peculiar circumstances many years ago threw into the hands of the writer many cases of epilepsy and analogous diseases; by the latter are intended such as the following: common convulsions, chorea, catalepsy, neuralgic affections, insanity, etc. etc.

In a series of articles for the *Boston Medical and Surgical Journal*, published in 1853 and 1854, I wrote as follows:—

"The writer has often been applied to, from persons at a distance, to treat epilepsy. Many of the applications have been by letter, from strangers, either the patients themselves or their friends; and have usually requested medicine to be sent. Such calls seem to indicate a want of information on medical subjects, or of a proper understanding of the nature of diseases. People seem to think, if one has recovered under the use of a particular medicine, all may be cured of the same disease by the same medicine. They are perfectly sincere on this subject. They are not aware that a disease which, like epilepsy, for in-

stance, appears the same, substantially, in all cases, which affects the nervous system, and manifests itself by a loss of consciousness and by convulsions, essentially the same in all, can arise from fifty different causes, and that each case requires the removal of *its particular exciting cause*.

"But such every medical man knows to be the fact. A man receives a bullet in his thigh, and it injures the great sciatic nerve, and epilepsy is the consequence. One falls from a building, and a fragment of bone of the cranium presses upon the brain, and epilepsy follows. Another eats an enormous quantity of indigestible substances, and has 'the glutton's groans;' the digestive apparatus is overpowered, and epilepsy ensues. Another overstretches and overtasks the intellect; becomes first nervous, then unable to command his mind—is then lost, and epilepsy follows. Another is half frightened out of his wits, and epilepsy is the consequence. Others have measles, small-pox, or intermittent fever, and they lead to epilepsy. These are not a tithe of the existing causes of epilepsy."

Indeed it is by no means an established fact that epilepsy *is* a disease. It is much more probable that it is merely the *manifestation* of some disease, poison, or irritation in the system, or arises from an abuse of the laws of our being.

Having seen many cases of epilepsy, both alone and in consultations, allow me to suggest, more especially to the younger members of the profession, my general plan of treatment:—

1. An absolute control must be maintained over the *diet*. I lay it down as an absolute law, as fixed as "the laws of the Medes and Persians," or as Napoleon's dynasty, that the patient must comply with the prescription as to *diet*, or the physician had better let him go. This I always do, where implicit compliance is refused. Let me give a case as a specimen:—

In the month of June, 1860, Rev. C. M. Breaker, of Charleston, South Carolina, came to this city to be treated by me for epilepsy. He was forty-six years old, naturally very strong and robust; had been subject to epileptic attacks about once in six weeks for the last three years. After a very careful inquiry into his habits of life, diet, etc., I was satisfied he had no *organic* disease. I told him I thought he would recover, if he would follow my advice.

"Well," said he, "what do you wish me to do?" I gave him a *bill of fare*, and told him to eat nothing else, with a prescription for some medicine. He sat thoughtful a few moments, then said, "*I will do it*." He *did* it, and had no more return of his attacks.

He had had one just before leaving Charleston, and probably would not have had another, living even as he had previously, for several weeks. The good effect of diet and medicine was such during these several weeks that he had no more. I had no doubt but the attacks were caused by eating *too much*, and of *unsuitable* food.

Of his own accord he published an account of his case in the denominational paper of this city, to which he belonged; and though he is now deceased, yet his last sickness had no connection with his former epilepsy.

To show the strength of his resolution, as well as the power of his appetite, he said to me one day, "I would give ten dollars for one good meal of *ham*, if I knew it would not injure me!" I told him I thought it would. With emphasis he replied, "*I won't touch it*." Such a perseverance in following advice, is what I mean when I say an absolute control must be maintained over the *diet*.

2. The next rule is, *govern the mind*. Unless this is done, the physician's prescription will be of but little use.

Many of these cases are induced by an ungoverned temper. This is the *epileptic devil* by which they are possessed; and he is generally fostered and strengthened by kind friends who feel that no government should be insisted upon, because he is a poor, sick epileptic, and, if crossed, *will have a fit*. Away with all such notions! If a child, break his will. Let him know that he must *mind, fits or no fits*. I could fill pages of your excellent journal with such cases, that have come under my own eye. "This kind will not go out by *fasting*" alone. The strong arm of *control of the mind* must be added to *diet* of the body.

One case of this ungoverned temper I may state here. It was while I was practicing in Boston. A young lady, an only daughter, I think an only child, came under my treatment. She did well for three months, and I was about letting her return home. She was to leave the next morning, and I said to her, at night, be calm; do not get excited. But the next morning, her aunt, with whom she had been stopping, sent for me early; and, upon my entering her room, said: "Rebecca has had a fit."

"What does this mean?" said I. "What has taken place?" For I was well aware that she was very excitable.

"Well," said the aunt, "I may as well tell the whole story. She was expecting a letter and some money from her father, last evening. The letter came, but it contained no money. She flew into such a passion that before she became calm she had a fit."

The result was, I kept her several months longer, and the *mad* demon having been mitigated or exorcised, she appeared well, and was allowed to return home, certainly much better, both in spirit and body, than when she came.

Meeting the physician who had previously attended her, some time after her return, and who was a gentleman of education, refinement, and skill equal to any of my acquaintance, he said: "I think I could have cured that girl as well as you did, if I could have controlled her temper and made her mind. But, under the eye of an indulgent father, a fond mother, and a doting grandmother, I could not do it."

This was exactly the case. That eminent physician knew the whole cause of the failure of his treatment. This illustrates what I mean when I say the *mind must be governed*.

3. Never let the patient *rust* out. Give him something to do. Better have something to do than to be idle, though it were to shovel sand from one side of the cellar to the other, and then back again, as old Dr. Lyman Beecher—the father of all the modern Beechers, and who had more brains than all of them—used to do, when he was a minister in Boston; or, as Stephen Girard made the beggar do, throw stones from one side of a lot to the other, and then throw them back. Great bodily fatigue, however, and much mental labor are to be avoided; while constant, moderate occupation should always be enjoined.

4. Make the patient abandon, at once and forever, any *exciting* cause of an attack, such as the use of spirit, wine, tobacco, excess in sexual pleasure, etc. etc.

5. Give such medicines as the case seems to indicate; *tonics* where tonics are needed, *alteratives* where alteratives are indicated, *anti-spasmodics* when the case demands them, etc. etc.

These ideas, I am aware, are all familiar to the old practitioners, but they may not be so deeply impressed upon the minds of the younger members of the profession as is desirable; and if this communication shall have an effect to draw their attention to them, my object will be accomplished.

WILLIAM M. CORNELL.

NEWS AND MISCELLANY.

Important Sanitary Rules for the Army.

HEADQUARTERS, DEPARTMENT OF THE SOUTH,
HILTON HEAD, PORT ROYAL, S. C.,
April 7, 1862.

GENERAL ORDERS, No. 5.—I. The Major-General Commanding desires to call the attention of all officers and men in this Department to the paramount necessity of observing rules for the preservation of health during the warm months upon which we have now entered. There is less to be apprehended from battle than disease; the records of all campaigns in climates such as this showing many more victims to the neglect of sanitary precautions than to the skill, endurance, or courage of the enemy. * * * Anxious that the men of his command may be preserved in the full enjoyment of health to the service of the Union, and that only those who can leave behind them the proud epitaph of having fallen on the battle-field, in defense of their country, shall fail to return to their homes and avocations on the termination of this unholy rebellion, the Major-General Commanding, in conformity with the excellent advice of Surgeon Geo. E. COOPER, U. S. A., Medical Director of the Department, hereby establishes the following rules for the sanitary government of all the troops at present serving, or hereafter to serve in Georgia, South Carolina, and Florida; and he will hold all officers, having the charge of camps or posts, to a strict responsibility for their enforcement.

II. Care will be taken, in the selection of camping-grounds, to avoid as much as possible the vicinity of malarious morasses or swamps; and the tents, in so far as practicable, are to be faced to the south. Each camp will be thoroughly policed twice each day, morning and evening, and all garbage or refuse matter will be collected and buried in the sinks.

III. Each tent will be screened or covered at the top and half way down the sides with an arbor of brushwood or palm-leaves, and shall be floored, whenever lumber can be procured, at an elevation of about three inches from the ground. When this cannot be done, each soldier will have a bunk raised eighteen inches from the ground, on side-poles, supported by forked sticks. All Quartermasters, to the extent of their ability, will furnish barrel staves, to be placed across these side-poles, and will issue the necessary lumber on receipt of proper requisitions.

IV. Tents will be struck at least three times each week, and every article of bedding and clothing taken out and aired; the flooring and bunks to be thoroughly cleaned before the tents are re-erected. On the days in which the tents are not struck, the sides will be raised, and kept raised, for the purpose of ventilation; and during the nights free ventilation will be secured by having the centre-seam in rear of the tent opened for the space of two feet, and kept open by the insertion of a forked stick. An officer of each company will inspect the tents of his men nightly, except

during stormy weather, to see that this important provision is carried out.

V. Sinks of the proper size, screened with brushwood or palmetto branches, shall be sunk at suitable distances on different sides of each camp; and the bottoms of these will be covered each morning with a layer of sand or clay, about a foot thick. It will be the duty of the camp-police to see that only the sinks on the lee side of the camp are used.

VI. Fresh meat is to be issued as often as practicable, and commanding officers, while near the sea-coast or any pieces of water in which fish exist, should encourage such of their men as are off duty, or not otherwise employed, to fish during the cool hours of the morning and evening—not later than 9 o'clock in the morning, and not earlier than 6 o'clock in the evening. In a scarcity of fresh meat those troops in the most exposed and unhealthy situations are to be the first served—for instance, the troops stationed in the batteries on the Savannah River; and to all troops so placed, a large share of vegetables, in addition to the ordinary rations, should be sent.

VII. Vegetables, fresh or preserved, must be issued frequently to all the troops, and an extra issue of coffee furnished to the men on guard during the night, just previous to their being marched to their respective stations. The Chief Commissary of the Department will see that the estimates and requisitions necessary to fulfill these requirements are forwarded to the Commissary-General without delay, and will report to these headquarters the failure of any Brigade or Regimental Commissaries to make due requisition for the supplies of the troops under their charge, in conformity with the terms of this order.

VIII. Breakfast will be ready for the men as soon as they leave their tents, which must not be till after sunrise. Except when immediately in face of the enemy, or when especially ordered by the commanding officer, reveille will not be sounded until half an hour after sunrise, by which time the sun's heat will have absorbed the miasma of the night-dews. All the men will be furnished with straw hats, and will be required to bathe or wash themselves thoroughly at least twice each week, and change their underclothing once a week, or oftener, if practicable. The hair and beard will be kept closely trimmed; and sentry-boxes of lumber or small shade arbors of brushwood will be erected at all points where sentries are permanently stationed. All soldiers on night picket or sentry duty will be provided with India-rubber ponchos.

IX. The proper cooking of provisions is a matter of great importance, more especially in this climate, but has not yet received from a majority of the officers in our volunteer service that attention which is paid to it in the regular army of the United States, and by the armies of Europe. Hereafter an officer of each company will be detailed to superintend the cooking of provisions, taking care that all food prepared for the soldiers is sufficiently cooked, and that the

meats are boiled or roasted, and not fried. With a little care bestowed on this point, and the advantages to both health and comfort of good cooking explained to the men, much good may be effected.

X. All soldiers on duty in districts especially malarious, or on unavoidable fatigue duty during the hot hours of the day, should be given quinine in prophylactic doses, each dose combined with half a gill of whisky each night and morning. The certificate of Regimental Surgeons will be requisite to cover such issues.

XI. Officers of the Medical Staff will see that the provisions of this order are complied with, and will promptly report any failure or neglect to the senior officers of the commands they are serving with, and to the Medical Director of this Department.

By command of

MAJOR-GEN. D. HUNTER.

CHAS. G. HALPINE, Assist. Adj.-General.

A large number of volunteer surgeons, many of them from this city, have gone to Fortress Monroe, in anticipation of their services being soon needed there.

Course of Lectures.—Prof. Leidy, of the University of Pennsylvania, has now in progress of delivery a course of twelve lectures on the subjects of General Natural History, Comparative Anatomy, and Physiology. They are delivered in the amphitheatre of the University on Tuesday of each week.

Dr. Everett, of Quincy, Illinois, Brigade-Surgeon in Gen. Prentiss' Division at the battle near Pittsburg Landing, Tenn., was killed early on Sunday morning, while endeavoring to rally a body of retreating troops.

Aid for the Wounded.—The Board of Managers of the Western Pennsylvania Hospital have placed the new "Dixmount Hospital" at the disposal of the Government, for the reception of the wounded at the late Pittsburg battle. It can accommodate five hundred patients.

Liberal Bequests.—The late Robert C. Goodhue, of New York, among other bequests, left \$3000 to the New York Hospital, \$2000 to the New York Dispensary, \$1000 to the Children's Aid Society, and \$1000 to the Deaf and Dumb Asylum.

Dr. Wm. B. Moffat, a celebrated manufacturer of proprietary medicines, by means of which he amassed a large fortune, died in New York on the 11th inst.

Dr. H. Hosmer, of Watertown, Mass., father of the gifted sculptor, Miss Hosmer, died in that town on Tuesday, April 15th. His daughter is absent in Rome. He was a skillful physician and an esteemed man.

The Medical Cadets.—A petition to the Senate has been sent in by the Medical Cadets of the United States Army, asking an increase of their rank and pay to that of Brevet-Second Lieutenant of Infantry. Their present pay is but thirty dol-

lars per month, which they claim is insufficient to meet their current expenses without assistance from friends.

Surgeon-General of the United States Army.—The President has nominated Surgeon Wm. A. Hammond, U. S. A., to the post of Surgeon-General of the United States Army. Dr. Hammond is a native of this State, and is favorably known for his attainments. Some two or three years since, he resigned his position in the army; but was reappointed last year, and has of late held the position of Chief Surgeon of the forces in Western Virginia.

University of Vermont.—There are a larger number of students attending the medical lectures of this institution during the present term than on any previous occasion. We are pleased to be able to record this evidence of prosperity.

Unusual Generosity.—In the last issue of the *San Francisco Medical Press*, Dr. Cooper gives a full list of all the regular medical journals in the United States, including the reprints, and makes the following proposition: To any person who is or shall become a subscriber to any of these named publications, he will send the *Press* for \$1.00 (i. e. half price;) to any one becoming a subscriber to two, he will send the *Press* for 50 cents; and free of charge to all who are or shall become subscribers to three. This proposition most assuredly conveys an earnest and sincere desire for the general diffusion of medical periodicals on the Pacific coast. It is as free from any taint of selfishness as it is high-toned and thoughtful.—*Lancet and Observer*.

Universal Medical Bibliography Society.—The *Union Medicale* suggests the organization of a society with this title. It is proposed that its headquarters be at Paris, with representation in all civilized nations.

An Alarmist.—We notice that a brigade-surgeon of one of Gen. Burnside's divisions has been relieved from duty, and ordered to report to the surgeon-general, at Washington, with a recommendation to the President that he be dismissed from the service. The charge brought against him, is that of being an alarmist. Rather small business, certainly, for a brigade-surgeon!

Suicides in France.—The average number of suicides in France amounts to 3899 annually—3057 men and 842 women. They are most frequent in the months of April, May, June, and July, and in ages from forty to sixty. In the last annual report there were 2833 suicides by hanging and drowning, 271 from asphyxia by charcoal fumes, 395 by fire-arms, 153 by cutting instruments, 110 by falls from heights, 98 by poisoning, and the remainder by various means.

Death of M. Meniere.—This eminent physician has just died at Paris, of pneumonia. He enjoyed a world-wide renown as director of the Paris Institution for the Deaf and Dumb, and had enriched periodical medical literature with writings of a most instructive kind.

Centennarians.—The number of those who die at or above the age of one hundred years in France is annually one hundred and forty-eight.

Prize Babies.—Mrs. Baines, the well-known sanitary philanthropist of Brighton, has issued a scheme for giving prizes to poor mothers who may prove successful in rearing healthy children. The scheme will involve a considerable amount of sound teaching to the poor mothers who are competitors, and has our best wishes.—*Times and Gazette*.

MARRIED.

JONES—FLEMING.—In New York, April 17th, by Rev. M. D. C. Crawford, Dr. Henry C. Jones, of Mt. Vernon, Westchester County, N. Y., and Ruthetta H. Fleming, of New York City.

DIED.

AYRES.—In Barnard, Vermont, April 5th, Dr. Henry C. Ayres, aged 39 years.

DRAYTON.—In this city, on the 19th of April, 1862, Dr. Henry E. Drayton, aged 59 years.

KING.—In this city, on the 14th inst., M. F. King, M.D., aged 67 years.

LEVERIDGE.—In New York, April 16th, Benjamin C. Leveridge, M.D., in the 63d year of his age.

MOTER.—At Hilltown, Bucks County, Pa., on the 12th inst., Dr. Joseph Moter, aged 40 years.

PEET.—In New York, April 18th, Dudley Peet, M.D., Professor in the Institution for the Deaf and Dumb, aged 31 years.

Vital Statistics.

OF PHILADELPHIA, for the week ending April 19, 1862.

Deaths.—Males, 158; females, 156; boys, 88; girls, 78. Total, 314. Adults, 148; children, 166. Under two years of age, 90. Natives, 231; Foreign, 58. People of color, 12.

Among the causes of death, we notice—Apoplexy, 5; convulsions, 16; croup, 4; cholera infantum, 1; cholera morbus, 1; consumption, 47; diphtheria, 7; diarrhoea and dysentery, 5; dropsy of head, 9; debility, 20; scarlet fever, 10; typhus and typhoid fever, 10; inflammation of brain, 8; of bowels, 7; of lungs, 23; bronchitis, 4; congestion of brain, 8; of lungs, 7; erysipelas, 4; hooping-cough, 6; marasmus, 10; small-pox, 7.

For week ending April 20, 1861.....314
" " April 19, 1862.....286

Population of Philadelphia, by the census of 1860, 568,034. Mortality, 1 in 1809.

OF NEW YORK, for the week ending April 21, 1862.

Deaths.—Males, 199; females, 196; boys, 108; girls, 98. Total, 395. Adults, 189; children, 206. Under two years of age, 129. Natives, 315; Foreign, 80; Colored, 7.

Among the causes of death, we notice—Apoplexy, 10; infantile convulsions, 32; croup, 7; diphtheria, 6; scarlet fever, 21; typhus and typhoid fevers, 9; cholera infantum, 0; cholera morbus, 0; consumption, 68; small-pox, 11; dropsy of head, 13; infantile marasmus, 12; diarrhoea and dysentery, 3; inflammation of brain, 9; of bowels, 15; of lungs, 31; bronchitis, 12; congestion of brain, 7; of lungs, 4; erysipelas, 5; hooping-cough, 4; measles, 1; 216 deaths occurred from acute disease, and 28 from violent causes.

For week ending April 22, 1861.....418
" " April 14, 1862.....393

Population of New York, by the census of 1860, 814,277. Mortality, 1 in 2061.5.

A more recent, and probably more correct census of New York gives a population of 805,554, which would give a mortality of 1 in 2039.06.

OF BOSTON, for the week ending April 12, 1862.

Deaths.—Males, 39; females, 41. Total, 80. Natives, 55; Foreign, 25.

Among the causes of death, we notice—Phthisis, 16; cholera infantum, 0; croup, 2; scarlet fever, 7; pneumonia, 10; variola, 2; dysentery, 0; typhus fever, 0; diphtheria, 0; hooping-cough, 1; convulsions, 1.

Population of Boston, 1860, 177,902. Average corrected to increased population, 83.29.